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
			, []
] [] 9/	, o
Preferred Method of Communication (S Phone Fax Email Contact Note: Producers must be under the same of information at http://www.mutualofc Application Submission Checklist	t info:ommission code to share or split commomaha.com/.	·	·
Provide Applicant with the Out	ed on age at application date emium form to determine rate licant Information Date s to be mailed on e claim number on the application . If this number is not available at mber by calling 1-877-617-5587 of the "eligibility" and "enrollment" of the Discount Information usehold Premium Discount	n. This number is	required for ion, the applicant/d. If not already
For Sections F and G – Refer to the Oper		sheet to help iden	tify eligibility.
Section F: Please answer all o If either Applicant A or B are in Section F, they can skip to Sections G & H: Health/Medic Do NOT answer if applicant Section I: Agreement and Autl Make sure applicant(s) sign Section K: To be Completed by Make sure producer(s) sign Complete the Method of Paym Use premium determined to The full modal premium is Complete Replacement Notice Provide Applicant with Premium Note: An interviewer may call to ve	f the following questions as wered "YES" to question BOTH to Section I ation Information is in an open enrollment or guarant horization and date the application of Producer and date the application ent form and return with the composition of the Calculate Your Premium for collected at the time of application and leave a copy with the application of Receipt signed by agent (if application of the composition of	questions 7(a) a teed issue period pleted applicati m on ant (if applicable vided on the app	nd 7(b) or question 8



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 <u>any</u> 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 statespecific 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 x .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. 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 x 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		\$454210, 0619



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 +



			DNIS_		Auth #		
Agent Writing #		Group # (it	f applicable)	Keylin	e		
Mutual Omaha Application for Medicare	A Mutual	i pplemental Ins u of Omaha Comp		3300 Mutual of Omaha, Nebrasl			
Applicant acknowledges and agrees	that if there is			application, all in	nformation pro	ovided ma	ay be
viewed or shared with the other app How Did You Hear About Us?	licant.						
Please select all that apply. Thank you	ı for providing t	his helpful info	rmation.				
Agent/Broker/Producer	Family Member/F	Friend	Physician Refer	rral	Social Media	a	
	Internet Search		Radio		TV		
A. Plan Information	(to be con	pleted by	Producer)				
Applicant A			<u> </u>	Applicant	B		
Plan (select one): Plan A	Plan G		Plan (select one):	Plan A	Plan G		
High Deductible Plan	G Plan N	1	L	High Deductible Pl		lan N	
If your Medicare Part A eligibility date is by plan is an available option: Plan F	efore 01/01/2020	D, this additional	If your Medicare Pa plan is an available Plan F	rt A eligibility date i	-	2020, this <u>a</u>	additiona
Requested Effective Date /	/		Requested Effectiv	e Date	//		
Deliver Policy to:			Deliver Policy to:				
Applicant A Producer			Applicant B	Producer			
B. Applicant Inform	ation						
Applicant A				Applicant	В		
Name (First/Middle Initial/Last)			Name (First/Mi	ddle Initial/Last))		
Residence Address			Residence Addr	ess			
City			City				
State	ZIP		State		ZIF)	
Mailing Address (if different from re	esidence addre	ess)	Mailing Address	s (if different fron	n residence ad	ldress)	
City			City				
State Z	IP L L		State		ZIP		
Home Phone area code) E-mail Address			Home Phone (a	rea code)			
L IIIaii Audiess			c-mail Address				
Current Age			Current Age				
Date of Birth /day	yr		Date of Birth	o day	/		

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B. Applicant Information (Continued)
Applicant A	Applicant B
☐ Male ☐ Female	☐ Male ☐ Female
Social Security #	Social Security #
Go paperless! To receive your Explanation of Benefits (EOBs) onli in Section B. If you subscribe, you will <u>not</u> receive paper EOBs, but become available with a link to access each specific EOB. We will reimbursement from Omaha Supplemental Insurance Company.	t instead, will receive an e-mail notification when new EOBs
Receive statement online? Y N	Receive statement online?
C. Medicare Information	
Please reference your Medicare card to complete this section	MEDICARE HEALTH INSURANCE Name/Nombre JOHN L SMITH Medicare Number/Número de Medicare 1EG4-TE5-MK72 Entitled to/Con derecho a HOSPITAL (PART A) MEDICAL (PART B) 03-01-2016 03-01-2016
Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date////	Medicare Part A Effective Date//
Medicare Part B Effective Date///	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 In	formation
You may be eligible for a policy with a lower premium rate base statements in this section. 1. Do you currently have a household resident (at least one, no real (a) with whom you have continuously resided for the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (a) with whom you reside and to whom you are either married of the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (b) with whom you have a household resident (at least one, no real with whom you have a household resident (at least one, no real with whom you have continuously resident for the last 12 months (b) with whom you reside and to whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with whom you are either married of the last 12 months (b) with a last 12 months (b) with whom you ar	more than three): and who is age 60 or older; or or in a civil union partnership? Ollowing information about the household resident, except
Name (First/Middle/Last)	
Date of Birth	
Street Address	

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City/State/ZIP

E. Previous or Existing Coverage Information

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 $\prod_{Y}\prod_{N}$ 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: $\square_{\mathsf{Y}} \square_{\mathsf{N}}$ (a) Will Medicaid pay your premiums for this Medicare supplement policy?..... (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your \square Y \square N \square Y \square N Medicare Part B premium?.... Please answer questions regarding another Medicare supplement or Select plan: 4. Do you have another Medicare supplement or Medicare Select insurance policy or $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$ certificate in force?..... If "YES," answer the following about this existing coverage: (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?..... (b) Indicate planned termination or disenrollment date...... Applicant A Applicant B (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 B** Applicant A 5. Have you had coverage from any Medicare plan other than Medicare Part A or B within \square Y \square N $\prod_{Y}\prod_{N}$ 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: (a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank...... Applicant A START Applicant B START (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... (c) Planned date of termination/disenrollment?...... Applicant A Applicant B (d) Was this your first time in this type of Medicare plan?..... (e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in $\exists \mathsf{Y} \square \mathsf{N}$ this Medicare plan?.... (f) Is your former Medicare supplement or Medicare Select policy/certificate still available? $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible

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 (g) Please indicate reason for termination/disenrollmen Your Medicare Advantage plan is leaving the Medicare Advantage organization stopped of the program of the program of the program of the geographic service area of the	offering Medicare Advantage plans offering coverage in the area your Medicare Advantage plan are Part D benefits and are enrolling
Applicant B	
Please answer questions regarding other health insu	rance:
 6. Have you had coverage under any other health insuran (For example, an employer group health plan, union plasupplement plan.) If "YES," answer the following about this previous or ex (a) What are your dates of coverage under the other poling lif you are still covered under this plan, leave "END" black the plan in th	an, or individual non-Medicare isting coverage: icy/certificate? ank
Applicant B	
(e) With what company and what kind of policy/certif	
Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type
F. Please answer all of the follow To the Best of Your Knowledge and Belief: 7. Are you applying during an open enrollment period?	/ing questions: Applicant A Applicant B
(a) Did you turn age 65 in the last six months?	
8. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for Peopif you are eligible. If the answer above is "YES," attach	Applicant B // // // // // // // // // // // // /

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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 9-21. Note: An interviewer may call to confirm and verify the information you have provided on this application.

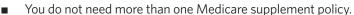
Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

T a		i. Medical Questions. (If TES is answered to any of the following questions 7-15, that person		
		Best of Your Knowledge and Belief:		Applicant B
		e you currently confined to a wheelchair or any motorized mobility device?e you currently hospitalized, confined to a bed, in a nursing home or assisted living	\square Y \square N	∐Y ∐N
	fac	cilíty?	\square Y \square N	\square Y \square N
11.		ave you been medically diagnosed with, treated for, or had surgery for any of the following: Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	$ \Box_{Y}\Box_{N} $	
	В.			∐Y ∐N
		pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	\square Y \square N	\square Y \square N
		Alzheimer's disease, dementia or any other cognitive disorder?	\square \square \square \square \square	\square Y \square N
	D.	Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	□Y□N	\square Y \square N
	E.	Systemic lupus, scleroderma or myasthenia gravis?	\square \square \square \square \square	\square Y \square N
	F.	Chronic hepatitis or cirrhosis?	\square Y \square N	\square Y \square N
	G.	Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?		$\square_{Y} \square_{N}$
12.	Hav	ve you had an organ or stem cell transplant or been advised to have an organ or stem cell insplant (excluding cornea implants)?	$\square_{Y} \square_{N}$	
12		you have Osteoporosis, and as a result, experienced a fracture?		
		you have diabetes with complications including retinopathy, neuropathy, peripheral artery	$ \square_{Y} \square_{N} $	∐Y ∐N
	dis	sease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart sorder or any kidney disease?	$\square_{Y} \square_{N}$	$\square_{Y} \square_{N}$
15.		you have an implanted cardiac defibrillator?	□Y □N	\square Y \square N
	L D	A A II I A A II A A A A A A A A A A A A		
and	l is s	: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person M subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being co	contains a "Yes	
and que	d is s estio	subject to an underwriting review.) If you would like consideration to be given to an application that	contains a "Yes ntrolled.	s" answer to any
and que To	d is s estio the . Wi	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition has existed and how it is being condition.	contains a "Yes	
To 16.	the the Wi trea Co	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have exatment for: bronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement?	contains a "Yes ntrolled.	s" answer to any
To 16.	the the trea . Co pla . Car per dis	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: bronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent	Applicant A Yes	Applicant B
To 16. A B	the treation Country Der dis imp	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being concepts of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have exament for: oronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? rdiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? coholism or drug abuse?	Applicant A Yes N Applicant A Y N Y N N N N N	Applicant B
To 16. A B	the treation that the treation continuation that the treation continuation that the treation that the treation that the treation continuation that the treation that the treat	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: oronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? rdiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? coholism or drug abuse? my mental or nervous disorder requiring treatment (including hospital confinement)?	Applicant A Yes N Applicant A Y N Y N Y N Y N N N N N N	Applicant B
To 16. A B	the . Wi trea Co pla Car per dis imp Alc Alc	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment? Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exatment for: Which is the past two years, have you been treated for, or been advised by a physician to have exit the past two years, have you been treated for, or been advised by a physician to have exit the past two years and years	Applicant A Yes N Applicant A Y N Y N Y N Y N N N N N N	Applicant B Y N Y N Y N
To 16. A B C D E F.	the . Wi tre Co pla . Cal per dis imp . Ald . And . Inte	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: Within the past two years, have you been treated for, or been advised by a physician to have exament for: Wording artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? Wording artery disease, angina, heart attack, cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? Wording abuse? Wording abuse? Wording abuse disorder requiring treatment (including hospital confinement)? Wording abuse are transient ischemic attack (TIA)?	Applicant A Yes N Applicant A Y N Y N Y N Y N N N N N N	Applicant B Y N Y N Y N
To 16. A B C D E F. G	the tree. Coplant Canal	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: or onary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? rediomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? coholism or drug abuse? ny mental or nervous disorder requiring treatment (including hospital confinement)? ernal cancer, lymphoma or melanoma? stroke or transient ischemic attack (TIA)? egenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that stricts mobility or have you been advised to have joint replacement?	Applicant A Yes N Applicant A Y N Y N Y N Y N Y N Y N Y N Y	Applicant B Y N Y N Y N
To 16. A B C D E F. G	d is sestion the tree. Will tree. Coopla per dis imp. Alco. And A series Do	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: incompary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? Incompositive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery dease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? Incomposition or drug abuse? In ymental or nervous disorder requiring treatment (including hospital confinement)? Incomposition or drug abuse? In ymental or nervous disorder requiring treatment (including hospital confinement)? Incomposition or drug abuse? In ymental or nervous disorder requiring treatment (including hospital confinement)? Incomposition or drug abuse? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital confinement)? In ymental or nervous disorder requiring treatment (including hospital con	Applicant A Applicant A Yes N N Y N N	Applicant B Y N Y N Y N
To 16. A B C D E F. G	the Winter Control of	subject to an underwriting review.) If you would like consideration to be given to an application that in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have latered for: oronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? ordiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? ordiomyopathy or drug abuse? ordiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? ordiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarter	Applicant A Applicant A Yes N N Y N Y N Y N Y N Y N Y N Y	Applicant B Y N Y N Y N
To 16. A B C D E F. G T7. A B	d is sestion the treat of the t	subject to an underwriting review.) If you would like consideration to be given to an application that in Part B, attach an explanation stating how long the condition has existed and how it is being confidence and subject to your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: bronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? crdiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? coholism or drug abuse? symmental or nervous disorder requiring treatment (including hospital confinement)? stroke or transient ischemic attack (TIA)? segenerative bone disease, spinal stenoise, rheumatoid arthritis, psoriatic arthritis, arthritis that stricts mobility or have you been advised to have joint replacement? you have diabetes with high blood pressure and have you: ken more than two medications for either condition (insulin dependent or oral medications)? d any changes in your medications within the past two years?	Applicant A Applicant A Yes N N Y N N	Applicant B Y N Y N Y N
To 16. A B C D E F. G 17. A B 18.	d is sestion the treat of the t	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being con Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: pronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? rdiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker?	Applicant A Applicant A Yes N N Y N Y N Y N Y N Y N Y N Y	Applicant B Y N Y N Y N
To 16. A B C D E F. G 17. A B 18.	d is sestion the wind	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being condition. Best of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: oronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement?	Applicant A Applicant A Y N Y N Y N Y N Y N Y N Y N Y	Applicant B Y N Y N Y N Y N Y N Y N Y N Y

G. Health Informa	<u>tion (cont</u>	.)				
To the Best of Your Knowledge					Applicant A	Applicant I
20. Have you used any form of the past 12 months?		_	_			
21. Applicant A (Height) Ft	ln L	(Weight) Lb	os Laboratoria de la companya de la		I	
Applicant B (Height) Ft		(Weight) Lb	os L			
7,pp.103.112 (115.3.11) 11 =		(110.3.13) =2	~ <u> </u>			
H. Medication In	<u>formatio</u>	n				
If you are applying for <u>ANY</u> the question. If "yes" list all prescribed in the last 2 years	over-the-cour	of an open enter or presci	enrollment or guara ription medications	nteed issue po you are curre	eriod, please a ntly taking or h	nswer nave been
To the Best of Your Knowledge					Applicant A	Applicant B
22. Are you currently taking, o prescription drugs or over-	r have you beer the-counter me	n prescribed duedications?	ıring the previous 2 ye	ears any		□Y□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/Con	dition
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			Y N	□Y □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/Con	dition
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□y □N	□Y □N		
			□y □N	□Y □N		

I. Agreement and Authorization

IMPORTANT STATEMENTS





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- 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 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO OMAHA SUPPLEMENTAL 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, United of Omaha 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 Omaha Supplemental 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, Omaha Supplemental 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 Omaha Supplemental Insurance Company has taken action in reliance on the authorization or the law allows Omaha Supplemental 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 Omaha Supplemental 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)

J. Producer Comments (please attach a separate sheet if needed)	
	_
	_
	_
K. To be Completed by Producer	
23. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s). (a) List policies/certificates sold to the applicant(s) which are still in force.	
Applicant A	
Applicant B	
(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.	
Applicant A	
Applicant B	
I/We certify as follows:	_
I/We have accurately recorded in the application the information supplied by the applicant(s)	N 1 .
I/We certify that we have interviewed the proposed applicant(s)] [
If you answered "NO" to any of the above statements, please explain why	
I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.	
Signature of Licensed Producer Date Signature of Licensed Producer Date	_
Printed Name Printed Name	_
Agent Writing Number Agent Writing Number	

5 A 6 O 3 5 - 2 C

SA6035-20

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
Initial premium amount (based on age at application date)	\$	\$
1. Paper Check (submit signed check with application)		
(California collect only one month's premium at time of application)		
2. Automatic Bank Account Withdrawal		
Ongoing Premium Payments (Select option #1a, #1b, or #2)	1 st through the 28 th or	1 st through the 28 th or
I want my payments automatically withdrawn from my bank a. Choose the day payments will be deducted every month from your bank account	the last day of every month	the last day of every month
OR	Week (1st, 2nd, 3rd, 4th, last)	Week (1 st , 2 nd , 3 rd , 4 th , last)
b. Choose the week and weekday that payments will be		
deducted every month from your bank account(For Example: 3rd Wednesday of every month)	Weekday (Mon, Tue, Wed, Thu, Fri)	Weekday (Mon, Tue, Wed, Thu, Fri)
I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing)	everymonths Insert 3, 6, or 12	everymonths Insert 3, 6, or 12
When choosing automatic bank account withdrawal, MONEY WILL BE V POLICY APPROVAL AND ISSUE. The first withdrawal date may be differ Depending on the amount of time elapsed between the policy date and to ongoing withdrawal may exceed one modal premium and may occur on a not receive premium billing notices while on this premium payment optic banks. Each month, payments will be automatically deducted from the account premiums will be deducted on the policy date (which is determined at the Ongoing deductions will begin once the policy is issued. If the scheduled will process on the following business day. Part II. Payor Information	ent from the monthly date selection date the policy is placed information and the policy date on. We CANNOT establish election on the day selected above time the policy is issued and content of the policy is placed information.	cted for ongoing premiums. rce, the amount of the first c. The Proposed Insured(s) will tronic payments from foreign e. If no date is selected, an be found within the policy).
	Applicant A	Applicant B
 Account Owner Name, if different than applicant's		



Part III. Account Information

Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> 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)				
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 Do NOT include the check # in			
 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. 	Account Holder Name the Routing or Account Number Street Address Town, City ZIP Code Pay to:			
I authorize Omaha Supplemental Insurance Company 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 Omaha Supplemental Insurance Company 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, Omaha Supplemental Insurance Company may require written confirmation from me within 14 days after my verbal notice.				
Applicant A	Applicant B			
£ 12	<u>£</u> 1			
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account			
 Date	Date			



S454216_1219



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 Omaha Supplemental 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	Applicant B
Additional benefits	Additional benefits
No change in benefits, but lower premiums	No change in benefits, but lower premiums
Fewer benefits and lower premiums	Fewer benefits and lower premiums
My plan has outpatient prescription drug coverage and I am enrolling in Part D	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)	Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
Other (please specify)	Other (please specify)
completely answer all questions on the application concerning your medical information on an application may provide a basis for the as though your policy had never been in force. After the application be certain that all information has been properly recorded.	e Company to deny any future claims and to refund your premiur on has been completed and before you sign it, review it carefully
Do not cancel your present policy or certificate until you have rec	ceived your new policy and are sure that you want to keep it.
Signature of Agent, Broker or Other Representative* Omaha Supplemental Insurance Company, 3300 Mutual of 0	Date Omaha Plaza, Omaha, NE 68175
Applicant A	Applicant B
Signature	Signature
Lo	
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 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 Omaha Supplemental 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	Applicant B
Additional benefits	Additional benefits
No change in benefits, but lower premiums	No change in benefits, but lower premiums
Fewer benefits and lower premiums	Fewer benefits and lower premiums
My plan has outpatient prescription drug coverage and I am enrolling in Part D	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)	Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
Other (please specify)	Other (please specify)
completely answer all questions on the application concerning your medical information on an application may provide a basis for the as though your policy had never been in force. After the application be certain that all information has been properly recorded.	e Company to deny any future claims and to refund your premiur on has been completed and before you sign it, review it carefully
Do not cancel your present policy or certificate until you have rec	ceived your new policy and are sure that you want to keep it.
Signature of Agent, Broker or Other Representative* Omaha Supplemental Insurance Company, 3300 Mutual of 0	Date Omaha Plaza, Omaha, NE 68175
Applicant A	Applicant B
Signature	Signature
Lo	
Date	Date
*Signature not required for direct response sales.	

Underwritten by Omaha Supplemental Insurance Company A Mutual of Omaha Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Premium Receipt

All premiums must be made payable to Omaha Supplemental Insurance Company.

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

Applicant A	Applicant B	
Received from	Received from	
this , , ,	this ,, ,,	_
an application for FormPolic	cy an application for FormPol	ісу
and/or Ridersand	d and/or Ridersar	nd
Check forDollars	. Check forDollar	S.
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, Omaha Supplemental 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.