District of Columbia — Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or are changing brokerage firms
		%	
		%	

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

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

Application Submission Checklist – Mutual of Omaha Medicare Supplement Coverage

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

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

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

Section D: Previous or Existing Coverage Information
- Please complete ALL questions in full

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

Section E: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section J: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Outline of Coverage**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**

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

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

MAP471_DC_1219

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

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Agent Writing # _____ FAV Key _____ Auth # _____

Group # (if applicable) _____ Keyline _____

Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance 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.

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): ☐ Plan A ☐ Plan D ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options: ☐ Plan C ☐ Plan F ☐ High Deductible Plan F	**Plan (select one):** ☐ Plan A ☐ Plan D ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options: ☐ Plan C ☐ Plan F ☐ High Deductible Plan F
Requested Effective Date ___ / ___ / ____	**Requested Effective Date** ___ / ___ / ____
Deliver Policy to Applicant A ☐ Producer ☐	**Deliver Policy to** Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/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 ___ – ___ – ____ (area code)	Home Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ___ / ___ / ____ (mo / day / yr)	Current Age _____ Date of Birth ___ / ___ / ____ (mo / day / yr)

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B. Applicant Information (continued)

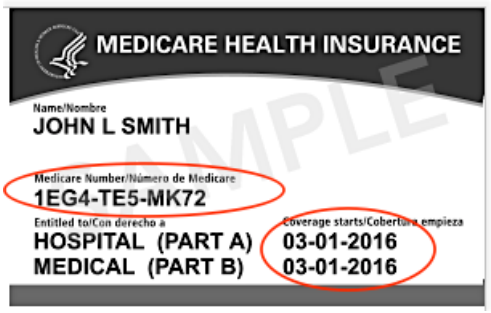
Applicant A	Applicant B
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___
Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N	Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N

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

Receive statement online? ☐ Y ☐ N	Receive statement online? ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	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 ___/___/____

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D. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:	**Applicant A**	**Applicant B**
1. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Y ☐ N	☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?	☐ Y ☐ N	☐ Y ☐ N

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

Applicant B ☐☐/☐☐/☐☐☐☐

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

Applicant A	**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**
3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

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

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

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

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

Applicant B ☐☐/☐☐/☐☐☐☐

(d) Was this your first time in this type of Medicare plan?.	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Y ☐ N	☐ Y ☐ N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:	Check box(s) below if applicable Applicant A	Applicant B
■ 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

Please answer questions regarding other health insurance:

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

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

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank.

Applicant A START ☐☐/☐☐/☐☐☐☐
END ☐☐/☐☐/☐☐☐☐
Applicant B START ☐☐/☐☐/☐☐☐☐
END ☐☐/☐☐/☐☐☐☐

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

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

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

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
5. Are you applying during a guaranteed issue period? (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N
6. Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
7. Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If "YES," indicate your effective date Applicant A ☐☐/☐☐/☐☐☐☐
Applicant B ☐☐/☐☐/☐☐☐☐

STOP **IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.**

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

F. Health Information

For all plans, answer questions 8-16.

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

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

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G. Medication Information

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

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ 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/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

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H. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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 MUTUAL OF OMAHA INSURANCE COMPANY

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

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

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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

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

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

J. To be Completed by Producer

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

Applicant A
Applicant B

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

Applicant A
Applicant B

I/We certify as follows:

I/We have provided a copy of the replacement notice if the applicant is replacing coverage ..... ☐ Y ☐ N

I/We have accurately recorded in the application the information supplied by the applicant ..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant ..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ **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. I want my payments automatically withdrawn from my bank a. Choose the day payments will be deducted every month from your bank account.....	1st through the 28th or the last day of every month	1st through the 28th or the last day of every month
OR		
b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)	_____ **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____	_____ **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

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 inforce, 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)	☐	☐
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

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Part III. Account Information

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

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

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

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

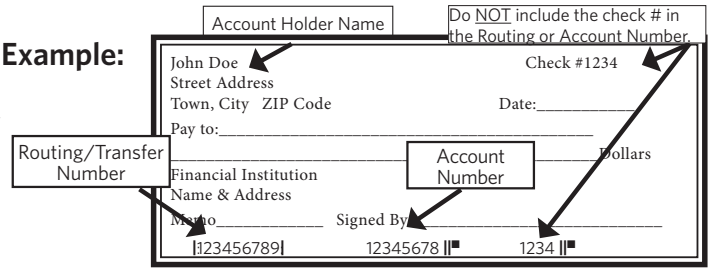
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



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

Applicant A

✍ _____
Authorized Signature as Shown on Account

_____
Date

Applicant B

✍ _____
Authorized Signature as Shown on Account

_____
Date

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MUTUAL *of* OMAHA INSURANCE COMPANY

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

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

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

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

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

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

Applicant A	**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)
_____	_____
_____	_____
_____	_____

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

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

✍ _____ _____

Signature of Agent, Broker or Other Representative* **Date**

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

Applicant A	**Applicant B**
Signature ✍	Signature ✍
Date	Date

*Signature not required for direct response sales.

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IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

Replacement Notice

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

Premium Receipt

MUTUAL *of* OMAHA INSURANCE COMPANY

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

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

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

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

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

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

Applicant A	**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)
_____	_____
_____	_____
_____	_____

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

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

✍ _____ _____

Signature of Agent, Broker or Other Representative* **Date**

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

Applicant A	**Applicant B**
Signature ✍	Signature ✍
Date	Date

*Signature not required for direct response sales.

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MUTUAL of OMAHA

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Premium Receipt

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

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

Applicant A

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

Applicant B

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

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

Provide the completed premium receipt, if applicable.

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