Proferred Method of Communication (Select one) Phone	Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or archanging brokerage firms
Preferred Method of Communication (Select one) Phone				
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 - Omaha Ins. Co. Medicare Supplement Coverage				6
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 — Omaha Ins. Co. 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 Tobacco rates do not apply during open enrollment or guaranteed issue situations Complete the Calculate Your Premium form to determine rate Application (complete in full) Sections A & B: Plan and Applicant Information Select plan Enter Requested Effective Date Indicate where the policy is to be mailed Section C: Medicare Information Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates. Section D: Household Premium Discount Information Indicate if eligible for a Household Premium Discount Section E: Previous or Existing Coverage Information Please complete ALL questions in full Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility. Section F: Please answer all of the following questions If either Applicant A or B answered "YES" to BOTH questions 7a AND 7b or question 8 in Section they can skip to Section I Section in Section in Section in Agreement and Authorization Make sure applicant is in an open enrollment or guaranteed issue period Section K: To be Completed by Producer Make sure producer(s) sign and date the application Complete the Method of Payment form and return with the completed application Complete Replacement Notice and leave a copy with the application Complete Replacement Notice and leave a copy with the ap	Preferred Method of Communic	ation (Select one)		
Application Submission Checklist — Omaha Ins. Co. 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 • Tobacco rates do not apply during open enrollment or guaranteed issue situations Complete the Calculate Your Premium form to determine rate Application (complete in full) Sections A & B: Plan and Applicant Information • Select plan • Enter Requested Effective Date • Indicate where the policy is to be mailed Section C: Medicare Information • Include applicant's Medicare number on the application. This number is required for electronic claim processing, If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates. Section D: Household Premium Discount Information • Indicate if eligible for a Household Premium Discount Section F: Previous or Existing Coverage Information • Please complete ALL questions in full for Sections F and G - Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility. Section F: Please answer all of the following questions • If either Applicant A or B answered "YES" to BOTH questions 7a AND 7b or question 8 in Section they can skip to Section 1 Sections 6 & H: Health/Medication Information • Do NOT answer if applicant is in an open enrollment or guaranteed issue period Section I: Agreement and Authorization • Make sure producer(s) sign and date the application Complete the Method of Payment form and return with the completed application Complete Replacement Notice and leave a copy with the applicant (if applicable) Provide Applicant with Premium Receipt signed by agent (if applicable) Complete the Notice of Other Health Insurance Coverage and return with the completed application.				
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Note: An interviewer may call to verify/confirm the information provided on the application.		Other Health Insurance Coverage a	nd return with the co	mpleted
		Il to verify/confirm the informatio	n provided on the app	lication.



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

Underwritten by Omaha Insurance Company A Mutual of Omaha Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Calculate Your Premium

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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 53114		
#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.	\$1,401.15		
#3	Optional Riders: Add the premium for the following optional riders selected: Part A Deductible Rider, Part B Deductible Rider, Part B Excess Rider, Additional Home Health Rider, Foreign Travel Rider. If none selected move on to Step #4.	\$1,401.15 + \$244.44 + \$20.40 = \$1,665.99		
#4	Optional Rider: Subtract the premium for the optional Part B Copay/ Coinsurance Rider, if selected. If not selected, move on to Step #5	\$1,665.99 - \$322.30 = \$1,343.69		
#5	Household Premium Discount Please refer to the application for state specific household discount premium rules. If the rules apply, multiply the last premium amount entered from Step #2, #3, or #4 by .88. If the rules do not apply, enter the last premium amount entered from Step #2, #3, or #4.	\$1,343.69 x .88 = \$1,182.45 In this example, the person qualifies for the household premium discount.		
#6	Rate Adjustment If you're in your open enrollment or guaranteed issue period, skip to Step #7. Locate your height, then weight on the next page. If your weight is in the Standard column, enter the amount from Step #5 If your weight is in the Class I or II column, multiply the amount from Step #5 by: 1.10 if in Class I column 1.20 if in Class II column	\$1,182.45 x 1.20 = \$1,418.94 Person's weight is in the Class II column.		
#7	Payment Options Your monthly payment is your last premium entered (Step #5 or #6). To determine other payment schedules, divide your annual premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$1,418.94 / 12 = \$118.24		M 0130 COLM



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 # (if	applicable) Keyline				
Mutual of Omaha Compan Application for Medicare Supplement Coverage	any				
Applicant acknowledges and agrees that if there is more than one viewed or shared with the other applicant.	applicant on this application, all information provided may be				
How Did You Hear About Us?					
Please select all that apply. Thank you for providing this helpful infor	mation.				
Agent/Broker/Producer Family Member/Friend	Physician Referral Social Media				
Direct Mail Internet Search	Radio				
A. Plan Information (to be completed by F	Producer)				
Applicant A	Applicant B				
Plan: Basic Plan - NM39 2020 High Deductible Plan - NM38	Plan: Basic Plan - NM39 2020 High Deductible Plan - NM38				
Optional Riders (only available with Basic Plan - NM39)	Optional Riders (only available with Basic Plan - NM39)				
OPN8F - Part A Deductible Rider OPN9F - Additional Home Care Rider OPP4F - Foreign Travel Emergency Rider OPP2F Part B Excess Charges Rider OPP3F Medicare Part B Co-Payment/Co-Ins. Deductible Rider -(not available with OPP1F - Part B Deductible Rider) OR If your Medicare Part A eligibility date is before O1/O1/2020, this additional rider is an available option: OPP1F - Part B Deductible Rider	OPN8F - Part A Deductible Rider OPN9F - Additional Home Care Rider OPP4F - Foreign Travel Emergency Rider OPP2F Part B Excess Charges Rider OPP3F Medicare Part B Co-Payment/Co-Ins. Deductible Rider -(not available with OPP1F - Part B Deductible Rider) OR If your Medicare Part A eligibility date is before O1/O1/2020, this additional rider is an available option: OPP1F - Part B Deductible Rider				
Requested Effective Date / / / /	Requested Effective Date / / /				
Deliver Policy to:	Deliver Policy to:				
Applicant A Producer	Applicant A Producer				
B. Applicant Information					
Applicant A	Applicant B				
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)				
Residence Address	Residence Address				
City	City				
State ZIP	State ZIP				
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)				
City	City				
State ZIP ZIP	State ZIP ZIP				

NA6012-47

Home Phone

(area code)

NA6012-47

Home Phone

(area code)

NA6012-47

Name (First/Middle/Last)

Date of Birth
Street Address

2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except

if both applicants are both applying for coverage on this application.

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 $\Box_{\mathsf{Y}} \Box_{\mathsf{N}}$ 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 this Medicare plan?.... $\square_{\mathsf{Y}} \square_{\mathsf{N}}$ \square Y \square N (f) Is your former Medicare supplement or Medicare Select policy/certificate still available?

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

NA6012-47

 (g) Please indicate reason for termination/disenrollment: Your Medicare Advantage plan is leaving the Medicar Your Medicare Advantage organization stopped offer Your Medicare Advantage organization stopped offer in which you live You moved out of the geographic service area of your You had a Medicare Advantage plan with Medicare Pain a stand-alone Medicare Part D plan Other: Applicant A	ing Medicare Advantage plans ing coverage in the area Medicare Advantage plan art D benefits and are enrolling	Applicant A	elow if applicable Applicant B
Applicant B			
Please answer questions regarding other health insurance	ce:		
6. Have you had coverage under any other health insurance w (For example, an employer group health plan, union plan, o supplement plan.) If "YES," answer the following about this previous or existin (a) What are your dates of coverage under the other policy/or If you are still covered under this plan, leave "END" blank	r individual non-Medicare g coverage: ertificate?	Applicant A	Applicant B
, ,			
	END Applicant B START END		/
(b) Planned date of termination/disenrollment?	Applicant A Applicant B		
(c) Have you disenrolled from your current coverage volun (d) Please state the reason for your disenrollment: Applicant A	tarily?	☐Y ☐N	N
· · · · · · · · · · · · · · · · · · ·			
Applicant B (e) With what company and what kind of policy/certificate	? (List below.)		
Applicant A	Applicant B		
Name of Company	Name of Company		
Policy/Certificate type	Policy/Certificate type		
F. Please answer all of the followin	g questions:		
To the Best of Your Knowledge and Belief: 7. Are you applying during an open enrollment period? (a) Did you turn age 65 in the last six months?		Applicant A Y N Y N	Applicant B
If either question 7a or 7b is "YES", indicate your Medicare Pa	Applicant B	 / / /	
8. Are you applying during a guaranteed issue period?(NOTE: Refer to the Guide to Health Insurance for People wif you are eligible. If the answer above is "YES," attach proo	vith Medicare to help identify f of eligibility.)	N SECTION F O	R ARE

OTHERWISE IN AIR OF EN ENGLEMENT PERIOD, SKII SECTIONS GRITAING GO TO SECTION II

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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 9-22. 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 9-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	1 1	
9. Are you currently confined to a wheelchair or any motorized mobility device?		
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?		∐Y ∐N
11. Have you been diagnosed or treated by a member of the medical profession, or had surgery for any of the following:	□Y □N	∐Y∐N
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	. 🗆 y 🗆 N	$\square_{Y} \square_{N}$
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic		
pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?		\square \vee \square \bowtie
C. Alzheimer's disease, dementia or any other cognitive disorder?		$\square_{Y} \square_{N}$
Disease), Huntington's disease, or cerebral palsy?		
E. Systemic lupus, scleroderma or myasthenia gravis?		= $=$ $=$ $=$
F. Chronic hepatitis or cirrhosis?	1 = . =	\square Y \square N
12. Have you been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)*?	□Y □N	□Y □N
*Reporting of HIV tests is limited to FDA licensed tests. Test results received at an anonymou couseling testing site or through an at home test does not need to be reported.	s Y N	\square Y \square N
13. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	□Y □N	□Y □N
14. Do you have Osteoporosis, and as a result, experienced a fracture?	:	\square Y \square N
15. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery		
diséase, peripheral venous thrombotic disease, stroke, transient ischemic áttack (TIA), any heart disorder or any kidney disease?	N DY	\square Y \square N
16. Do you have an implanted cardiac defibrillator?		\square \vee \square \bowtie
Part P. Madical Overtions: (If "VES" is appropriate any of the following questions 17.20 that parents	ا:م:ام مطاهم ۱:م:ا	ala fau aassauana
Part B: Medical Questions: (If "YES" is answered to any of the following questions 17-20 that person and is subject to an underwriting review.) If you would like consideration to be given to an application to		
Part B: Medical Questions: (If "YES" is answered to any of the following questions 17-20 that person and is subject to an underwriting review.) If you would like consideration to be given to an application that question in Part B, attach an explanation stating how long the condition has existed and how it is being c	at contains a "Yes	
and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being c	at contains a "Yes ontrolled.	s" answer to any
and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled to the Best of Your Knowledge and Belief:	at contains a "Yes	
and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:	at contains a "Yes ontrolled.	s" answer to any
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? 	at contains a "Yes ontrolled.	s" answer to any
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, 	at contains a "Yesontrolled. Applicant A	Applicant B
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery 	at contains a "Yesontrolled. Applicant A	Applicant B
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, 	Applicant A Yes	Applicant B
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker? 	at contains a "Yesontrolled. Applicant A Y N Y N	Applicant B
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition to the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or 	Applicant A Y N Y N Y N Y N	Applicant B
 and is subject to an underwriting review.) If you would like consideration to be given to an application the question in Part B, attach an explanation stating how long the condition has existed and how it is being condition in Part B, attach an explanation stating how long the condition has existed and how it is being condition in Part B, attach an explanation stating how long the condition has existed and how it is being conditions. To the Best of Your Knowledge and Belief: 17. 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? B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker? C. Alcoholism or drug abuse? 	at contains a "Yestontrolled. Applicant A Y N Y N Y N Y N Y N	Applicant B Y N Y N Y N
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G. Health Information	<u>tion (cont.</u>	.)				
To the Best of Your Knowledge					Applicant A	Applicant I
21. Have you used any form of the past 12 months?		_	_	-	l — —	
·				••••••		1 LY L
22. Applicant A (Height) Ft						
Applicant B (Height) Ft	In	(Weight) Lb	s			
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	plan <u>OUTSIDE</u> over-the-coun s.	of an open e ter or prescr	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	e and Belief:				Applicant A	Applicant B
23. Are you currently taking, o prescription drugs or over-	r have you been the-counter me	prescribed du dications?	ring the previous 2 ye	ars any		□y□N
Applicant A					Į.	
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		-1	ı		I	
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		



I. Agreement and Authorization

IMPORTANT STATEMENTS



- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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 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 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 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 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 Insurance Company has taken action in reliance on the authorization or the law allows Omaha 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 Insurance Company.

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

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

NA6012-47

J. Producer Comments (please attach a separate sheet if needed)	
K. To be Completed by Producer	
24. 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
I/We certify that we have interviewed the proposed applicant(s)Y	\
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	

JA6012-47

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)		\$
(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)	at the	ast up and and
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 28 th or the last day of every month
OR	Week (1 st , 2 nd , 3 rd , 4 th , 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	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 VPOLICY APPROVAL AND ISSUE. The first withdrawal date may be differed between the policy date and to ongoing withdrawal may exceed one modal premium and may occur on not receive premium billing notices while on this premium payment optic banks.	rent from the monthly date select he date the policy is placed info a date other than the policy date	cted for ongoing premiums. rce, the amount of the first c. The Proposed Insured(s) will
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.	e time the policy is issued and c	an be found within the policy).
Part II. Payor Information		
•	Applicant A	Applicant B
 Account Owner Name, if different than applicant's		



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)					
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) Payments cannot be postponed until a later date. Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations. All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.	Applicant B				
I authorize Omaha Insurance Company to withdraw funds from my a understand that the amounts may differ. This authorization shall apply shortages may result from a variety of causes, including underwriting my account to Omaha Insurance Company any preauthorized bank a be fully protected in honoring any such payment and that its rights a if the payment were signed personally by me. I agree to notify the b This authorization will be effective until I give you at least three busin Insurance Company may require written confirmation from me within Applicant A Authorized Signature as Shown on Account	y to any future payments unless specifically revoked by me. Premium g adjustments. I authorize my financial institution to pay from account withdrawals. I agree that my financial institution shall and responsibilities regarding the payment shall be the same as usiness in writing of any changes in my account information. ness days' notice to cancel. If notice is given verbally, Omaha in 14 days after my verbal notice. Applicant B Authorized Signature as Shown on Account				
Date	Date				



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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

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

According to your application, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by 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, Medicare cost, Medicare select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select 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, Medicare cost, Medicare select, or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select 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 you medical information on an application may provide a basis for the as though your policy had never been in force. After the application to be certain that all information has been properly recorded.	e Company to deny any future claims and to refund your premium
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*	Date
Omaha Insurance Company, 3300 Mutual of Omaha Plaza, (
Applicant A	Applicant B
Signature	C: .
	Signature
Date Date	T





List a	ny other health insura	nee poney you nave	sold to the rippi	icant that is still in	ioree.	
List a	ny other health insura	nce policy you have	sold to the Appl	icant in the past fiv	ve (5) years that is n	o longer in fo

TO BE COMPLETED BY AGENT



Date

Agent's Signature

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, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

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

According to your application, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by 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, Medicare cost, Medicare select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select 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, Medicare cost, Medicare select, or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select 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 you medical information on an application may provide a basis for the as though your policy had never been in force. After the application to be certain that all information has been properly recorded.	e Company to deny any future claims and to refund your premium
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*	Date
Omaha Insurance Company, 3300 Mutual of Omaha Plaza, (
Applicant A	Applicant B
Signature	C: .
	Signature
Date Date	T





List a	ny other health insura	nee poney you nave	sold to the rippi	icant that is still in	ioree.	
List a	ny other health insura	nce policy you have	sold to the Appl	icant in the past fiv	ve (5) years that is n	o longer in fo

TO BE COMPLETED BY AGENT



Date

Agent's Signature



Premium Receipt

All premiums must be made payable to Omaha Insurance Company.

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

Applicant A		Applicant B	
Received from		Received from	
this , , ,		this day of ,	
an application for Form	_Policy	an application for Form	Policy
and/or Riders	and	and/or Riders	and
Check forD	ollars.	Check for	_Dollars.
Agent		🕰 Agent	

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, 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.