



Mgr/Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc Marketer	Application Reviewed By
PLAN INFORMATION (to be completed by Producer)		
Policy Form	Requested Effective Date:	
Spouse applying for coverage (different application)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Premium Collected (based on age at application date) \$	Initial Mode A, S, Q or B	
Renewal S	Renewal Mode A, S, Q or B (monthly not allowed)	

Application To Mutual of Omaha Insurance Company For Medicare Supplement Coverage

PART I. GENERAL INFORMATION

1. Print Name _____ Home Phone No (_____) _____
(Title) (First) (Middle) (Last) (Area Code)
2. Residence Address _____
(No and Street and Apt No) (City) (State) (ZIP Code)
3. Mailing Address _____
(No and Street and Apt No) (City) (State) (ZIP Code)
4. Birth Date ____/____/____ Age ____ Male Female
Mo Day Yr (current age)
5. Social Security No _____ E-mail Address _____
6. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage? Yes No
7. Have you used tobacco in any form in the past 12 months? Yes No

PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

- To the best of your knowledge:
1. Are you covered under Medicare? Part A Yes No Part B Yes No
 If "Yes," give your Medicare card number. _____ If "No," when will you become eligible? ____/____/____
Mo Day Yr
 2. Did you turn age 65 in the last 6 months?..... Yes No
 3. Did you enroll in Medicare Part B in the last 6 months? Yes No
 If "Yes," indicate your effective date. ____/____/____ If "No," indicate date you plan to enroll. ____/____/____
Mo Day Yr Mo Day Yr
 4. Are you applying during a guaranteed issue period?..... Yes No
 (NOTE: If the answer above is "Yes" please attach proof of eligibility.)

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 that you had certain rights to buy such a policy, 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.**

5. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____

Name of Company	Kind of Policy	Policy/Certificate Number

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... Yes No
- (c) If yes, have you received a copy of the replacement notice? Yes No
- (d) Reason for termination/disenrollment? _____
- (e) Planned date of termination/disenrollment ____/____/____
- (f) Was this your first time in this type of Medicare plan? Yes No
- (g) Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)..... Yes No

(a) If so, with what company and what kind of policy?

Name of Company	Kind of Policy

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

START ____/____/____ END ____/____/____

(c) Reason for termination/disenrollment? _____

(d) Date of termination/disenrollment ____/____/____

7. (a) Do you have another Medicare supplement insurance policy in force? Yes No

(b) If so, with what company, and what plan do you have?

Name of Company	Policy/Certificate Number	Plan	Issue Date

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

(d) If "Yes," indicate termination date. ____/____/____ **Have you received a copy of the Replacement Notice?** Yes No
Mo Day Yr

8. 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.)..... Yes No

If yes, (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?..... Yes No

9. Producers shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

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

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

PART III. HEALTH /MEDICAL QUESTIONS (COMPLETE IN FULL)

1. If the answer is "Yes" to any of the following health questions (a)-(m) or question 2, you are not eligible for coverage. (If you are applying for coverage during an open enrollment or guaranteed issue period, do not answer questions 1 -4 in Part III. If you are applying for Plan N outside of an open enrollment or guaranteed issue period, only answer question 4 in Part III. If you are applying for any plan other than Plan N and you are outside of an open enrollment or guaranteed issue period, answer questions 1 - 3 in Part III.)

- (a) Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?.. Yes No
- (b) Have you been diagnosed with or treated by a physician for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disease?
- (c) Have you been diagnosed with or treated by a physician for Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis?
- (d) Have you been diagnosed with or treated by a physician for Alzheimer's, senile dementia, organic brain disease, or any other senility disease?.....
- (e) Have you been diagnosed with or treated by a physician for diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (**including** high blood pressure) or kidney disease?
- (f) Do you have diabetes that has ever required more than 50 units of insulin daily?.....
- (g) Within the past two years have you been treated by a physician for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse; cirrhosis; mental or nervous disease requiring psychiatric care; or have you had any amputation caused by disease?
- (h) Within the past two years have you been treated by a physician for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure); peripheral vascular disease; congestive heart failure or enlarged heart; stroke; transient ischemic attacks (TIA), or heart rhythm disease?..
- (i) Within the past two years have you been treated by a physician for degenerative bone disease, crippling/disabling or rheumatoid arthritis, or have you been advised to have a joint replacement?

- (j) Have you been advised by a physician that surgery may be required within the next twelve months for cataracts?
 - (k) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ...
 - (l) Have you been hospital confined three or more times in the last two years?
 - (m) Have you had an organ transplant or been advised by a physician to have an organ transplant?
2. Have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? Yes No
3. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
If "Yes," please list the drug and the condition. (Use page 4 of application, if more space is necessary.)

Medication Name (copy off pharmacy label)	Date Originally Prescribed	Frequency and Dosage	Diagnosis/Condition

4. IF APPLYING FOR PLAN N OUTSIDE OF AN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD - Please answer this REQUIRED question:
Do you have End Stage Renal Disease (ESRD) or have you been treated for or diagnosed with chronic renal failure, with or without dialysis?Yes No

I represent that my answers and statements are true and complete and agree that no insurance will be effective unless a policy is issued.

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- (a) You do not need more than one Medicare supplement policy.
- (b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.
- (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (d) If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (f) 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).

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Dated at _____, on _____, _____
(City) (State) (Month) (Day) (Year) (Signature of Applicant)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Licensed Producer) PRODUCER STAMP

Producer Name (Please Print) First Initial Last

Florida License Identification Number(s)

Policy Delivery

Mail policy to:

Applicant Producer

Producer(s) Information

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

(Note: Producers must be under the same commission code to share or split commissions.)

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

Is the applicant: Yes No

(a) unemployed?.....

(b) employed, but not working for the business that is paying the premium?

(c) the business owner or spouse of the business owner?

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

Is the applicant: Yes No

(a) unemployed?.....

(b) employed, but not working for the business that is paying the premium?

(c) the business owner or spouse of the business owner?

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (ACH/BSP) FORM

Account Holder Name	Check Number		
John Doe Street Address Town, City Zip code			
Check #1234 Date: _____			
Pay to: _____ _____ Dollars			
Bank Name & Address			
Memo _____ Signed By: _____			
⑆123456789⑆ 12345678 ⑆ 1234 ⑆			
Bank Routing/ Transfer Number	Bank Account Number	Check Number (if shown at bottom, may be before or after the account #)	Do NOT include the check number as part of either the Routing or Account Number.

The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).

Automated Clearing House (ACH) is used for initial payment and **Bank Service Plan (BSP)** is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)

When choosing to pay the initial premium by ACH and renewal premiums by direct billing (annually, semiannually, or quarterly), the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premium by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments can not be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the ACH/BSP form accurately and in its entirety, making sure that all required information is correct and complete on your ACH/BSP form prior to submission. In addition, please make sure that the premium amount is filled in on the ACH/BSP form, so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

- | Medicare Supplement Premium Payment Options: | YES | NO |
|---|--------------------------|--------------------------|
| A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer.....
(ACH is used for initial payment and BSP is used for renewal payments.) | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Pay initial premium by signed paper check and pay monthly renewals by BSP | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Pay initial premium by ACH and pay renewals by direct bill (monthly direct billing is not offered) | <input type="checkbox"/> | <input type="checkbox"/> |
| • If choosing Options A or C, list amount of initial premium withdrawal, if applicable..... | \$ _____ | |
| • If choosing Options A or B,
select a withdrawal date for monthly BSP renewal payments (circle one) | 1st | or 15th |
| • Is a business account being used to pay premiums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • If yes, is the applicant: | | |
| (a) Unemployed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Employed, but not working for the business that is paying the premium | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) The business owner or spouse of the business owner | <input type="checkbox"/> | <input type="checkbox"/> |
- If (a), (b), or (c) are "Yes," premiums CAN be paid with a business account.**

Account Type (check one): Checking Savings

Complete information below. To avoid potential delays in processing, submit a copy of a voided check.

 Name of Financial Institution

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

 Account Number (Do NOT use Debit or Credit Card account numbers)

 Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize Mutual of Omaha and/or United World Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha and/or United World Life Insurance Company to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha and/or United World Life Insurance Company. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Authorized Signature as Shown on Account

Date

**PLEASE SIGN AND RETURN THIS AUTHORIZATION
WITH YOUR COMPLETED APPLICATION**

Appendix 1 Florida – Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

Meanings of Terms

“Medical Persons and Entities” means: all physicians, 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.

“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 and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

“Psychotherapy Notes” means: 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.

“Specified Companies” means:

- 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, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

Purposes

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

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.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant’s policy.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

Printed Name of Proposed Insured

Spouse’s Printed Name
(If Proposed Insured)

If children are to be insured, their printed names

Signature of Proposed Insured

Signature of Spouse
(If Proposed Insured)

Signature of Parent or Guardian
(If Proposed Insured is a Minor)

Date

Date

Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

MLU23202_FL_0910

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 information you have furnished, 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 you 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 Agent: I have reviewed your current medical and 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 (check one):

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

If you still wish to terminate your present policy 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 to be certain that all information has been properly recorded. Do not cancel you present policy until you have received your new policy and are sure that you want to keep it.

Agent's Signature **X** _____

Applicant's Signature **X** _____ Date _____

M20133_0605 1 - Home Office Copy

Certification

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. _____ offered by Mutual of Omaha Insurance Company, to _____.

That, I have explained the provisions of the Policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

That, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the Amount of \$ _____ which has been paid to me by check money order credit card.

That, I have clearly explained that the benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

That, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent **X** _____ Date _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant **X** _____ Date _____