**United of Omaha Life Insurance Company**
A Mutual *of* Omaha Company
P.O. Box 3608 Omaha, Nebraska 68103-3608

## Application Submission Checklist To United of Omaha For Medicare Supplement Coverage – CALIFORNIA

**THIS APPLICATION MUST BE USED TO WRITE UNITED OF OMAHA MEDICARE SUPPLEMENT PRODUCTS**

☐ **Application**

1. Complete "Plan Information" Box.
2. Refer to the Outline of Coverage for policy forms.
3. Answer all questions in full.
4. **Applicants applying for Plan N:**
   - during an Open Enrollment or Guaranteed Issue period should SKIP SECTIONS 4 & 5 AND GO TO SECTION 6.
   - outside of an Open Enrollment or Guaranteed Issue period and are **REPLACING** other coverage should SKIP SECTION 4 and COMPLETE SECTIONS 5 & 6.
   - outside of an Open Enrollment or Guaranteed Issue period and are **NOT REPLACING** other coverage should COMPLETE SECTION 4 THEN GO TO SECTION 6.
5. Sign and Date in all places indicated.
6. Be sure to leave all applicable forms with the proposed insured.
7. See reverse side of this page for additional detailed information.

☐ **Collect Premium Amount**

- The full modal premium is collected at the time of application.
- Calculate the premium based on age at time of application.
- Follow instructions on page 1 of **Calculate Your Premium form (UC6582_0208)** to calculate the premium. Complete the form and return with the application.

☐ **Provide Client with Buyer's Guide**

☐ **Provide Client with Outline of Coverage**

☐ **Complete Producer Information page**

☐ **If applicable, complete the Authorization for Electronic Funds Transfer form (ACH/BSP form U7535_0409) and return with the completed application**

- Withdrawal of the initial premium payment will occur when the application is processed.

☐ **Provide Client with Conditional Receipt signed by agent (if applicable), and provide Client with Notice of Information Practices**

☐ **Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form U7566_CA_0610). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**

☐ **Complete Replacement Notice (U7563_CA) and leave a copy with the applicant (if applicable)**

☐ **Complete Senior 24-hour meeting Notice (U8381_CA) and leave with the applicant**

☐ **Please have Client sign and date the Guaranteed Issue and Open Enrollment Notice for California (U8378_CA) and give copy to Client.**

**Please provide additional information and comments in the space provided on the application.**

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**Note: An interviewer may call to verify/confirm the information provided on the application.**

**BROKERAGE ONLY – Please list your "commission code" in the box on the first page of the application. This will help avoid delay in commission payment.**

**There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.**

## 1. Application – Agent Completes in Full: (please print)

**"Plan Information" Box**

- Policy Form
- Requested Effective Date
- Premium Collected (Amount) - Follow instructions on page 1 of Calculate Your Premium form (UC6582_0208) to calculate the premium. Complete the form for Applicants A & B (if applying) return with the application.
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, B=Automatic Funds Withdraw, or ACH=Automated Clearing House)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
  *Direct Monthly billing not available

**Section 1 "General Information"–**

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant's current age at time of application.
- The applicant's Social Security number as indicated from applicant's Social Security Card.
- For applicants already covered by Medicare, include applicant's Medicare number on the application as indicated from the applicant's Medicare Health Insurance Card. 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.
- The applicant's current Height in feet and inches and Weight in pounds.

**Sections 2 and 3 "Existing Coverage Information"–**

- Please complete all questions in full.
- If the applicant is not covered by Medicare, indicate "Eligibility Date" and "Date of Enrollment".
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
  – Name of Company
  – Policy/Certificate Number
  – Plan
  – Issue Date
  – Termination/Disenrollment Date
  – Kind of Policy

**NOTE:** An interviewer may call to verify/confirm the information provided on the application.

## 2. Administrative Forms

**Producer/Agent Information**

- Be sure to include your Social Security number and commission code.
  **NOTE: This information is necessary for the underwriting process and commission payment.**
- Include your telephone number, e-mail address and FAX number for contact purposes.

**Authorization for Electronic Funds Transfer by United of Omaha Life Insurance Company (ACH/BSP) –**
**If applicant chooses to pay premium by ACH/BSP, complete this form accurately and in its entirety and return with the application.**

- **Option A** - Pay all premiums (1st & monthly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium MUST be submitted with the application
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment.

**Conditional Receipt and Notice of Information Practices**

- Complete and sign the receipt (if applicable), detach entire page and leave with applicant.

**Authorization To Disclose Personal Information (HIPAA)**

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.

**Replacement Notice – complete if applicable**

- Complete form including signature and date.
- Leave a copy with applicant (if applicable).

**State – Specific Forms – complete if applicable**

- Be sure to include all state appropriate forms.

Group number (if applicable):_____

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Application For Medicare Supplement Coverage

| Mgr./Commission Code (Required Field For Brokerage) | District Sales Manager/Assoc. Marketer | Application Reviewed By |
|---|---|---|
| | | |

**PLAN INFORMATION** (to be completed by **Producer**)

**NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.**

| **Applicant** | **Applicant B** |
|---|---|
| **Policy Form** | **Policy Form** |
| Requested Effective Date | Requested Effective Date |
| Premium Collected (**based on age at application date**) $ | Premium Collected (**based on age at application date**) $ |
| Initial Mode ☐**A,** ☐**S,** ☐**Q,** ☐**or** ☐**ACH** | Initial Mode ☐**A,** ☐**S,** ☐**Q,** ☐**or** ☐**ACH** |
| Renewal $ | Renewal $ |
| Renewal Mode ☐**A,** ☐**S,** ☐**Q,** ☐**B** (monthly not available) | Renewal Mode ☐**A,** ☐**S,** ☐**Q,** ☐**B** (monthly not available) |

## 1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

| **Applicant** | **Applicant B** |
|---|---|
| Name (First/Middle/Last) | Name (First/Middle/Last) |
| Residence Address | Residence Address (if different from Applicant's) |
| 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 No (_____)_____ (area code) | Home Phone No (_____)_____ (area code) |
| Current Age _____ Date of Birth_____/____/_____ mo day yr | Current Age _____ Date of Birth_____/____/_____ mo day yr |
| Male ☐ Female ☐ | Male ☐ Female ☐ |
| Social Security No | Social Security No |
| Medicare Health Insurance Card Number (if known) | Medicare Health Insurance Card Number (if known) |
| E-mail Address | E-mail Address |
| Height Weight<br>Ft _____ In _____ Lbs _____ | Height Weight<br>Ft _____ In _____ Lbs _____ |

## 2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

| | APPLICANT | APPLICANT B |
|---|---|---|
| 1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 2. Have you used tobacco in any form in the past 12 months? (If answered "No," you will be eligible for a discount on your premium.) | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 3. If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **To the Best of Your Knowledge:** | | |
| 1. Are you covered under Medicare Part A? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| If "YES," what is your Part A effective date? _____ (Applicant) / _____ (Applicant B) | | |
| If "NO," what is your eligibility date? _____ (Applicant) / _____ (Applicant B) | | |
| 2. Are you covered under Medicare Part B? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| If "YES," what is your Part B effective date? _____ (Applicant) / _____ (Applicant B) | | |
| If "NO," indicate date you plan to enroll. _____ (Applicant) / _____ (Applicant B) | | |
| 3. Did you turn age 65 in the last six months? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 4. Did you enroll in Medicare Part B in the last six months? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| If "YES," indicate your effective date. _____ (Applicant) / _____ (Applicant B) | | |

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 such as open enrollment, 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.**

## 3. FOR YOUR PROTECTION, we ask the following questions about insurance policies or certificates you may have.

| To the Best of Your Knowledge: | Applicant | Applicant B |
|---|---|---|
| 1. Are you applying during a guaranteed issue or open enrollment period? (NOTE: Please attach proof of eligibility if in a guaranteed issue period.) | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 2. Do you have another Medicare supplement insurance policy or certificate or health care service plan in force? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (a) If "YES," with what company, and what plan do you have? | | |

| Applicant | Applicant B |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Plan | Plan |
| Issue Date ___/___/___ | Issue Date ___/___/___ |

| | | |
|---|---|---|
| (b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (c) If "YES," indicate termination date. ___/___/___ (Applicant) / ___/___/___ (Applicant B) | | |
| (d) **If "YES," have you received a copy of the replacement notice?** | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.** | | |
| 3. If you had coverage from any Medicare plan other than 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 ___/___/___ (Applicant) / START ___/___/___ END ___/___/___ (Applicant B) | | |
| (a) 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 ☐ | Yes ☐ No ☐ |
| (b) **If "YES," have you received a copy of the replacement notice?** | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B) | | |
| (d) Planned date of termination/disenrollment? ___/___/___ (Applicant) / ___/___/___ (Applicant B) | | |

| | Applicant | Applicant B |
|---|---|---|
| (e) Was this your first time in this type of Medicare plan? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (g) Is your former Medicare supplement or Medicare select policy/certificate still available? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan) | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (a) If "YES," with what company and what kind of policy? (List below) | | |

| Applicant | | Applicant B | |
|---|---|---|---|
| Name of Company | 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 _____/_____/_____ / START _____/_____/_____ END _____/_____/_____
Applicant Applicant B

(c) Reason for termination/disenrollment? _____ / _____
Applicant Applicant B

(d) Planned date of termination/disenrollment? _____/_____/_____ / _____/_____/_____
Applicant Applicant B

| | | |
|---|---|---|
| 5. Are you covered for medical assistance through the state Medicaid or Medi-Cal 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," | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (a) Will Medicaid or Medi-Cal pay your premiums for this Medicare supplement policy? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| (b) Do you receive any benefits from Medicaid or Medi-Cal OTHER THAN payment toward your Medicare Part B premium? | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 6. Producers shall list any other health insurance policies they have sold to the applicant. | | |
| (a) List policies sold which are still in force. | | |

| Applicant | Applicant B |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage | Effective Date of Coverage |

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

| Applicant | Applicant B |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage | Effective Date of Coverage |

**If you are applying during an Open Enrollment or Guaranteed Issue period, SKIP SECTIONS 4 & 5 and GO TO SECTION 6.**

**If applying for plans other than Plan N:**

- **If you are applying outside of an Open Enrollment or Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and then GO TO SECTION 6.**

**If applying for Plan N:**

- **If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and are REPLACING other coverage, SKIP SECTION 4 and COMPLETE SECTIONS 5 & 6.**
- **If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and do NOT currently have a Medicare supplement, Medicare Advantage, or employer group health plan, PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and then SKIP TO SECTION 6.**

(Please see the enclosed material for explanation of the Open Enrollment and Guaranteed Issue periods.)

## 4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" or "NOT SURE" to any of the following questions 1-14, that person is not eligible for coverage.

| To the Best of Your Knowledge: | Applicant | Applicant B |
|---|---|---|
| 1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 2. Within the past five years, have you been diagnosed with or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 3. Within the past five years, have you been diagnosed with or treated for Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 4. Within the past five years, have you been diagnosed with or treated for Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 5. Within the past five years, have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.** | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 6. Within the past five years, have you been treated for diabetes in addition to any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do **not** have diabetes, this question should be answered "NO". | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 7. Within the past five years, have you been treated for diabetes that has ever required more than 50 units of insulin daily? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 8. Within the past two years, have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 9. Within the past two years, have you been treated 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 disorders? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 10. Within the past two years, have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 12. Within the past two years, have you been advised by a physician to have any type of surgery, diagnostic medical tests (excluding HIV/AIDS), treatment or therapy that has not been performed or had test(s) for which you have not received the results? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 13. Have you been hospital confined three or more times in the last two years? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 14. Within the past five years, have you had an organ transplant or been advised by a physician to have an organ transplant? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table. | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |

| **Applicant** (please attach a separate sheet if needed) | | **Applicant B** (please attach a separate sheet if needed) |
|---|---|---|
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |

## 5. IF YOU ARE APPLYING FOR MEDICARE SUPPLEMENT PLAN N OUTSIDE OF AN OPEN ENROLLMENT OR GUARANTEED ISSUE PERIOD AND ARE REPLACING OTHER COVERAGE (including Medicare supplement, Medicare Advantage, group medical, etc.) – Please Answer These REQUIRED Questions. If you answer "YES" or "NOT SURE" to any of the following questions 1-4, you will NOT be eligible for coverage.

| To the Best of Your Knowledge: | APPLICANT | APPLICANT B |
|---|---|---|
| 1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 2. Within the past two years have you been advised by a physician to have any type of surgery, diagnostic medical tests (excluding HIV/AIDS), treatment or therapy that has not been performed or had test(s) for which you have not received the results? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 3. Within the past five years, have you been diagnosed with or treated for either of the following? | | |
| A. Kidney disease requiring dialysis? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| B. Chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 4. Within the past two years have you been treated for or been advised by a physician to have treatment for a heart attack; heart, coronary, or carotid artery disease; or heart rhythm disorders? | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |
| 5. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table. | Yes ☐ No ☐ Not Sure ☐ | Yes ☐ No ☐ Not Sure ☐ |

| **Applicant** (please attach a separate sheet if needed) | | **Applicant B** (please attach a separate sheet if needed) |
|---|---|---|
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |

## 6. HOUSEHOLD DISCOUNT INFORMATION – Please Answer BOTH Questions 1 & 2 In This Section.

| **You may be eligible for a policy with a lower rate based on your answers to the statements in this section.** | APPLICANT | APPLICANT B |
|---|---|---|
| 1. I have continuously resided with another person for the last 12 months or are married and they are also applying for this coverage. If "YES," please complete the information regarding Relationship to Applicant below, unless you AND Applicant B are applying for coverage on THIS application then do not complete the Relationship to Applicant information. | Yes ☐ No ☐ | Yes ☐ No ☐ |
| 2. I have continuously resided with another person for the last 12 months or are married and they have an existing Medicare supplement policy or certificate with Mutual of Omaha Insurance Company or United World Life Insurance Company or United of Omaha Life Insurance Company. If you answer "YES," to this question, please complete the information regarding Relationship to Applicant below. | Yes ☐ No ☐ | |

**Relationship to Applicant:**

First Name

Last Name

Street Address

City State ZIP

Policy/Certificate Number

## 7. PLEASE READ AND SIGN BELOW

**IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- 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 or Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid or Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid or Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid or Medi-Cal. If you are no longer entitled to Medicaid or Medi-Cal, 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 or Medi-Cal 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 Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free telephone number (1-800-927-HELP), your local HICAP office, or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's Signature

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

**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) (Signature of Licensed Producer)

_____ _____
PRODUCER STAMP PRODUCER STAMP

| ADDITIONAL INFORMATION: PART 4 Question #15 or PART 5 Question #5 - CON'T. HEALTH /MEDICAL QUESTIONS | | |
|---|---|---|
| **Applicant** (please attach a separate sheet if needed) | | **Applicant B** (please attach a separate sheet if needed) |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |

| SECTION FOR ADDITIONAL COMMENTS | |
|---|---|
| **Applicant** (please attach a separate sheet if needed) | **Applicant B** (please attach a separate sheet if needed) |
| | |
| | |
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| | |

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Calculate Your Premium

Medicare Supplement

## Medicare Supplement Plan _____

***Before you begin:*** *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

| Line | Steps | Example<br>Rate displayed is used for calculation purposes only. | Applicant's Premium | Applicant B's Premium |
|---|---|---|---|---|
| #1 | **Premium**<br>Write in your Med supp plan's premium from the Outline of Coverage provided. | $128.52 | | |
| #2 | **Household Discount**<br>Are you eligible to receive a household discount?<br>If yes, multiply line #1 by .93.<br>If no, enter the amount from line #1. | $128.52 x .93 = $119.52<br><br>In this example, the person qualifies for the household discount. | | |
| #3 | **Rate Adjustment**<br>*If you're in your open enrollment or guarantee issue period, skip to step #4.*<br>On page 2, locate your height, then weight.<br><br>If your weight is in the Standard column, enter the amount from line #2.<br><br>If your weight is in the Class I or II column, multiply the amount on line #2 by:<br>1.10 if in 10% column<br>1.20 if in 20% column | $119.52 x 1.20 = $143.42<br><br>Person's weight is in the Class II 20% column. | | |
| #4 | **Payment Options**<br>Your monthly payment is your last premium entered (line #2 or #3).<br>To determine other payment schedules, multiply your monthly premium by:<br>3 to pay 4 times a year (quarterly)<br>6 to pay twice a year (semiannually)<br>12 to pay once a year (annually) | $143.42 monthly payment<br><br>$430.26 quarterly payment<br>$860.52 semiannual payment<br>$1,721.04 annual payment | | |

**Complete and return with application**

# Height and Weight Chart

## Eligibility

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

## Rate Adjustment

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

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

Medicare supplement insurance is underwritten by
**United of Omaha Life Insurance Company**
A Mutual *of* Omaha Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
*mutualofomaha.com*

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Policy Delivery

Mail policy/policies to:

a) Applicant ☐ Producer ☐

b) Applicant B ☐ 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? | ☐ | ☐ |

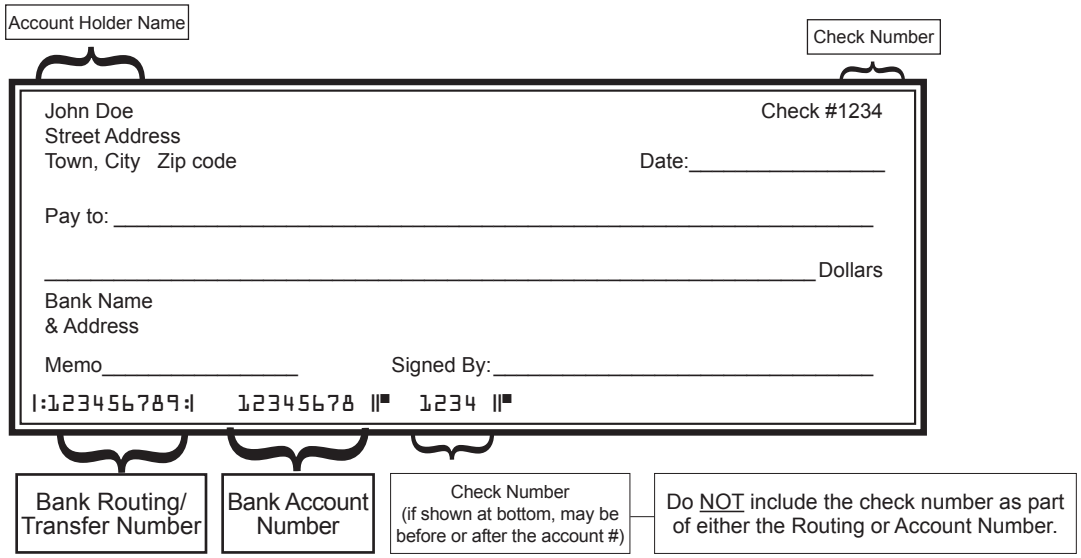
If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

**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




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 all 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 premiums by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), 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 premiums 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 cannot 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 Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer 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.

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Please refer to instructions on the Front of this form.

## 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:** | **Applicant A** YES | **Applicant A** NO | **Applicant B** YES | **Applicant B** 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.) | ☐ | ☐ | ☐ | ☐ |
| B. Pay 1st premium by signed paper check and pay monthly renewals by BSP | ☐ | ☐ | ☐ | ☐ |
| C. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)** | ☐ | ☐ | ☐ | ☐ |
| • If choosing Options A or C, list amount of initial premium withdrawal | $ _____ | | $ _____ | |
| • If choosing Options A or B, select a withdrawal date for monthly renewal payments (circle one) | ☐ 1st or 15th | ☐ | ☐ 1st or 15th | ☐ |
| • Is a Business Account being used to pay premiums? | ☐ | ☐ | ☐ | ☐ |
| • If yes, is the applicant: | | | | |
| (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) are "Yes," premiums CAN be paid with a business account.**

**Applicant A**

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

**Account Type (check one):** ☐Checking ☐Savings

_____
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

**Applicant B**

**Account Type (check one):** ☐Checking ☐Savings

_____
Name of Financial Institution

_____
Routing Number (first 9 digits on the 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 United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize United of Omaha 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 United of Omaha. 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**

_____
**Authorized Signature as Shown on Account**

_____
**Date**

**United of Omaha Life Insurance Company**
A Mutual *of* Omaha Company

**Please sign and return this authorization with your completed application**

# CALIFORNIA - Authorization To Disclose Personal Information To United of Omaha Life 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. 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 to United of Omaha Life Insurance Company.

### Purposes

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 only be required if the applicant is not in an open enrollment or guaranteed issue period.

### 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
United of Omaha Life 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 United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.

### 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): _____

| **Applicant** | **Applicant B** |
|---|---|
| Printed Name of Proposed Applicant | Printed Name of Proposed Applicant |
| Signature of Proposed Applicant | Signature of Proposed Applicant |
| Date | Date |

# United of Omaha Life Insurance Company

A Mutual *of* Omaha 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.**

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by United of Omaha Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

**Statement to Applicant from the insurer and agent:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

| **Applicant** | **Applicant B** |
|---|---|
| _____ Additional benefits that are: | _____ Additional benefits that are: |
| _____ | _____ |
| _____ 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 reasons specified here: | _____ Other reasons specified here: |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

✗ _____

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

[United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175]

| **Applicant** | **Applicant B** |
|---|---|
| Signature | Signature |
| Date | Date |

*Signature not required for direct response sales.

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Guaranteed Issue and Open Enrollment Notice for California

**Requirements for individuals who are eligible for Guaranteed Issue.**

(1) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.

(2) Enrolled in a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following apply:

- (a) The certification of the organization or plan has been terminated; or
- (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or
- (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary; or
- (d) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual; or
- (e) The individual demonstrates, either of the following:
  - The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
  - The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (f) The individual meets other exceptional conditions as the secretary may provide.

(3) Individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider and circumstances exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) Individual meets both of the following conditions:

- (a) Individual is enrolled with any of the following:
  - An eligible organization under a contract of the Social Security Act (Medicare cost).
  - A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.
  - An organization under an agreement of the Social Security Act (health care prepayment plan).
  - An organization under a Medicare Select policy; or
- (b) Enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) Individual is enrolled under a Medicare supplement policy, and enrollment ceases because of any of the following circumstances:

- (a) Insolvency of the issuer or bankruptcy of the non-issuer organization, or other involuntary termination of coverage or enrollment under the policy; or
- (b) The issuer of the policy substantially violated a material provision of the policy; or
- (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(6) Individual meets both of the following conditions:

- (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider of the Social Security Act, or a Medicare Select policy; and
- (b) The subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment).

(7) Individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) Individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy.

(9) During a period of guaranteed issuance of any Medicare supplement coverage, the applicant is not required to sign a HIPAA form.

**Requirements for individuals who are eligible for Open Enrollment.**

(1) (a) A policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(b) An issuer shall make available Medicare supplement benefit plans A, B, C and F, if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease.

(2) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.

(3) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(a) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(b) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(c) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(4) An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(5) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

(6) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

I have read the Guaranteed Issue and Open Enrollment Notice and understand that if I am eligible for Guarantee Issue, I am not required to provide health information on my application.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

# IMPORTANT DOCUMENTS

CLIENT FORMS

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 if applicable.

**Replacement Notice** (If replacing, both you and the applicant must sign the customer copy of the replacement notice)

**Senior 24-Hour Meeting Notice**

**Guaranteed Issue and Open Enrollment Notice**

**Conditional Receipt / Notice of Information Practices**

# United of Omaha Life Insurance Company

A Mutual *of* Omaha 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.**

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by United of Omaha Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

**Statement to Applicant from the insurer and agent:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

| **Applicant** | **Applicant B** |
|---|---|
| _____ Additional benefits that are: | _____ Additional benefits that are: |
| _____ 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 reasons specified here: | _____ Other reasons specified here: |

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

✗ _____

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

[United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175]

| **Applicant** | **Applicant B** |
|---|---|
| Signature | Signature |
| Date | Date |

*Signature not required for direct response sales.

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Dear _____

Thank you for agreeing to meet with me on _____
Date Time

During this meeting, or a follow-up meeting, we will be discussing the following:

A sales presentation on:

☐ Life insurance

☐ Annuities

☐ OTHER insurance_____

In Addition:

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

You have the right to contact the Department of Insurance for information, or to file a complaint at 1-800-927-4357.

The following individuals will be coming to your home:

_____
Name License #

_____
Name License #

Sincerely,

United of Omaha Life Insurance Company Representative

Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company
Health Insurance Underwritten by Mutual of Omaha Insurance Company
[Both at Mutual of Omaha Plaza, Omaha NE, 68175]

# United of Omaha Life Insurance Company

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## Guaranteed Issue and Open Enrollment Notice for California

**Requirements for individuals who are eligible for Guaranteed Issue.**

(1) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.

(2) Enrolled in a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following apply:

- (a) The certification of the organization or plan has been terminated; or
- (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or
- (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary; or
- (d) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual; or
- (e) The individual demonstrates, either of the following:
  - The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
  - The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (f) The individual meets other exceptional conditions as the secretary may provide.

(3) Individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider and circumstances exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.

(4) Individual meets both of the following conditions:

- (a) Individual is enrolled with any of the following:
  - An eligible organization under a contract of the Social Security Act (Medicare cost).
  - A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.
  - An organization under an agreement of the Social Security Act (health care prepayment plan).
  - An organization under a Medicare Select policy; or
- (b) Enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).

(5) Individual is enrolled under a Medicare supplement policy, and enrollment ceases because of any of the following circumstances:

- (a) Insolvency of the issuer or bankruptcy of the non-issuer organization, or other involuntary termination of coverage or enrollment under the policy; or
- (b) The issuer of the policy substantially violated a material provision of the policy; or
- (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(6) Individual meets both of the following conditions:

- (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider of the Social Security Act, or a Medicare Select policy; and
- (b) The subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment).

(7) Individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.

(8) Individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy.

(9) During a period of guaranteed issuance of any Medicare supplement coverage, the applicant is not required to sign a HIPAA form.

**Requirements for individuals who are eligible for Open Enrollment.**

(1) (a) A policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

(b) An issuer shall make available Medicare supplement benefit plans A, B, C and F, if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease.

(2) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.

(3) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(a) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(b) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.

(c) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

(4) An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(5) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

(6) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

I have read the Guaranteed Issue and Open Enrollment Notice and understand that if I am eligible for Guarantee Issue, I am not required to provide health information on my application.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Conditional Receipt

### Check or Money Order Application

All premiums must be made payable to the United of Omaha Life Insurance Company.

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

**Applicant**

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

**Applicant B**

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

**NOTICE TO APPLICANT:** Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

**If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.**

**Complete Receipt in full and leave with applicant at time of application.**

## United of Omaha Life Insurance Company - Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

**Give this notice to the applicant.**