Mutual of Omaha Insurance Company
P.O. Box 3608 Omaha, Nebraska 68103-3608

Application Submission Checklist To Mutual of Omaha For Medicare Supplement Coverage – DISTRICT OF COLUMBIA

THIS APPLICATION MUST BE USED TO WRITE MUTUAL 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. Sign and Date in all places indicated.
5. Be sure to leave all applicable forms with the proposed insured.
6. 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.

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

☐ **Provide Client with Outline of Coverage**

☐ **Complete Producer Information page**

☐ **Complete Bank Service Plan (ACH/BSP) Authorization Form - M26238_1107 (if applicable)**

☐ **Provide Client with Conditional Receipt signed by agent**

☐ **Complete, sign and provide client with copy of the Authorization To Disclose Personal Information - HIPAA form MLU23202_0603. This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**

☐ **Complete Replacement Notice - M18362-49_0605 and leave a copy with the applicant (if applicable)**

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

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)
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, B=Bank Service Plan, or ACH)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
  *Direct Monthly billing not available

Part I "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.

Part II "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 – Issue Date
  – Policy/Certificate Number – Termination/Disenrollment Date
  – Plan – 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 to Withdraw Funds by Mutual of Omaha Insurance Company (ACH/BSP) – Complete If Applicable

- If completing the initial premium portion, do not send a check. Use the IDN fax cover sheet when faxing applications.
- Renewal payments will be taken monthly, on the 1st or the 15th of the month. You do not need to provide a voided check if complete account information is provided on form.

Conditional Receipt

- Complete, sign, detach 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 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.

MUTUAL *of* OMAHA INSURANCE COMPANY

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 ☐ No ☐
Premium Collected $	Initial Mode **A, S, Q or B**
Renewal $	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 _____ Sex: M ☐ F ☐ Height:_____Ft. _____ In. Weight _____Lbs.
   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 _____/____/_____
   (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. ____/____/____ (Mo Day Yr) **Have you received a copy of the Replacement Notice?** ..... Yes ☐ No ☐

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)-(n), you are not eligible for coverage. (If you are applying for coverage during open enrollment or during a guaranteed issue period, do not answer questions 1 & 2 in section III.)**

	Yes	No
(a) Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	☐	☐
(b) Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐	☐
(c) Have you been diagnosed with Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis?	☐	☐
(d) Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder?	☐	☐
(e) Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
(f) Do you have diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (**including** high blood pressure) or kidney disease?	☐	☐
(g) Do you have diabetes that has ever required more than 50 units of insulin daily?	☐	☐
(h) 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; cirrhosis; mental or nervous disorder requiring psychiatric care; or have you had any amputation caused by disease?	☐	☐
(i) 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?	☐	☐
(j) 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?	☐	☐
(k) Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	☐	☐
(l) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐	☐
(m) Have you been hospital confined three or more times in the last two years?	☐	☐
(n) Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐	☐

2. 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

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 reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
(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 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.
(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 defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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	(Signature of Licensed Producer) PRODUCER STAMP	(Signature of Licensed Producer) PRODUCER STAMP

ADDITIONAL INFORMATION: PART III - CON'T. HEALTH /MEDICAL QUESTIONS - Question #2.

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

SECTION FOR ADDITIONAL COMMENTS:

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.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company or United World Life Insurance Company

Note: This form is intended as authorization to debit your account. Please complete initial and/or renewal premium payment sections, as applicable.

Initial Premium Payment (When selecting Initial Premium payment, do NOT send payment by check)

Indicate ☐ Checking Account or ☐ Savings Account

Please fill in your account information or attach a voided check. Bank Name_____

Routing Number|_|_|_

Conditional Receipt

Check or Money Order Application

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

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

Received of _____

this _____day of _____, _____an application

for a Form _____ Policy and 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.

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, Exclusive Healthcare, Inc., 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.

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

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

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

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

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare coverage. The replacement policy is being purchased for the following reason(s) (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) _____

_____

_____

_____

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. 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 premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

_____
(Signature of Agent, Broker or Other Representative)*

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

_____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

1 – Home Office Copy 2 – Applicant Copy

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_____ Fewer benefits and lower premiums
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_____ Other (please specify) _____

_____

_____

_____

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3. 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 premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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_____
(Signature of Agent, Broker or Other Representative)*

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

_____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

1 – Home Office Copy 2 – Applicant Copy