



Application Submission Checklist To Mutual of Omaha For Medicare Supplement Coverage – VERMONT

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 Replacement Notice (M18362_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.

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.



Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:
PLAN INFORMATION (to be completed by Producer)		
Policy Form	Requested Effective Date:	
Spouse applying for coverage (different application)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Premium Collected \$	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

- Print Name _____ Home Phone No. (_____) _____
(Title) (First) (Middle) (Last) (Area Code)
- Residence Address _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Mailing Address _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Birth Date ____/____/____ Age ____ Sex: M F Height: ____ Ft. ____ In. Weight ____ Lbs.
Mo Day Yr (current age)
- Social Security No. _____ E-mail Address: _____
- Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage? ..Yes No
- Do you have End Stage Renal Disease (ESRD)? Yes No

PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

To the best of your knowledge:

- 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
- Did you turn age 65 in the last 6 months?..... Yes No
- 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
- 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.**

- 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 ____/____/____
 - 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
 - If "Yes," have you received a copy of the replacement notice? Yes No
 - Reason for termination/disenrollment? _____

(e) Planned date of termination/disenrollment ____ / ____ / ____

(f) Was this your first time in this type of Medicare plan? Yes No

(g) Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

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

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

Name of Company	Kind of Policy

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

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

(c) Reason for termination/disenrollment? _____

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

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

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

Name of Company	Policy/Certificate Number	Plan	Issue Date

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

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

8. Are you covered for medical assistance through the state Medicaid program? [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]..... Yes No

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

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

(c) Do you receive any benefits from the Vermont Health Access Plan (VHAP) program? 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

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 III. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

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

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

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?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) employed, but not working for the business that is paying the premium?	<input type="checkbox"/>	<input type="checkbox"/>
(c) the business owner or spouse of the business owner?	<input type="checkbox"/>	<input type="checkbox"/>

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

Renewal Payment

Is the applicant:	Yes	No
(a) unemployed?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) employed, but not working for the business that is paying the premium?	<input type="checkbox"/>	<input type="checkbox"/>
(c) the business owner or spouse of the business owner?	<input type="checkbox"/>	<input type="checkbox"/>

If (a), (b), or (c) 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 | | | | | | | | | | _____
(First 9 digits on the lower left hand side of check)

Account Number | | | | | | | | | | _____

Is this a business account? Yes No

I authorize Mutual of Omaha Insurance Company or United World Life Insurance Company to debit the bank account shown above for the first premium payment shown below at the time my application is processed. I understand the amount authorized for the initial premium payment may be different than the amount authorized for the renewal premium payment.

Initial Premium Payment Amount \$ _____

Name as Shown on Account (please print)	
Authorized Signature as Shown on Account	Date

If the person paying the initial premium payment is not the Applicant for insurance, please complete this section:

Joint Account or Other Authorized Name (please print)	
Joint Account or Other Authorized Signature	Date

Renewal Premium Payment

Complete the Bank Service Plan below and submit with the application if premium payments are to be withdrawn from your bank account.

Indicate Checking Account or Savings Account

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

Routing Number | | | | | | | | | | _____
(First 9 digits on the lower left hand side of check)

Account Number | | | | | | | | | | _____

Is this a business account? Yes No

Complete the following only if you are adding the above coverages to an existing BSP.

Name of Insured Under Existing BSP	Existing BSP Policy Number
------------------------------------	----------------------------

Specify Date of Withdrawals 1st of the Month 15th of the Month

I authorize you to pay and charge my account any checks, drafts or preauthorized electronic fund transfer made upon my account by, and payable to the order of, Mutual of Omaha Insurance Company or United World Life Insurance Company. I agree that your rights with respect to each charge will be the same as if it were personally executed by me. This authorization is to remain in effect until I give you, and my financial institution, at least three business days' notice to revoke it, provided, however, if notice is given orally, then you may require a written confirmation from me within 14 days after the oral notification.

Name as Shown on Account (please print)	
Authorized Signature as Shown on Account	Date

If the person paying the initial premium payment is not the Applicant for insurance, please complete this section:

Joint Account or Other Authorized Name (please print)	
Joint Account or Other Authorized Signature	Date

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.

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 or certificate to be issued by Mutual of Omaha Insurance Company. Your new policy or certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy or certificate.

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 or certificate.

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 or certificate will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy or certificate 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) _____

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

Do not cancel your present policy or certificate until you have received your new policy or certificate 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.

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

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

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.