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 – SOUTH CAROLINA

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. 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.
- 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**

☐ **Complete Bank Service Plan (ACH/BSP) Authorization Form - (U7535_0208) (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 U7566). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**

☐ **Complete Replacement Notice (U7564) 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) - Follow instructions on page 1 of Calculate Your Premium form (UC6582_0208) to calculate the premium. Complete the form return with the application.
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, B=Bank Service Plan/ACH)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
  *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 to Withdraw Funds by United of Omaha Life 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.

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 **Policy Form**	**Applicant B** **Policy Form**
Requested Effective Date	Requested Effective Date
Premium Collected $	Premium Collected $
Initial Mode **A, S, Q, B, or ACH**	Initial Mode **A, S, Q, B, 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 Ft _____ In _____ Weight Lbs _____	Height Ft _____ In _____ Weight 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?	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 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last 6 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, 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, the National Association of Insurance Commissioners requests that 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 period? (NOTE: If the answer above is "YES" please attach proof of eligibility.)	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate 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-f)] [(a-g)] below. If not, skip to question #4.		
3. 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 ____/____/____ (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 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 ☐	Yes ☐ No ☐
If "YES,"		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid 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 Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

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" 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 ☐	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
6. If you have diabetes, do you have 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 ☐	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐	Yes ☐ No ☐
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 ☐	Yes ☐ No ☐
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 ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐	Yes ☐ No ☐

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	

5. HOUSEHOLD DISCOUNT INFORMATION

You may be eligible for a policy with a lower rate based on your answers to the statements in this section.	Applicant	Applicant B
a. 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 provide the following information. If you and Applicant B are applying for coverage on this application, do not fill out the following information.	Yes ☐ No ☐	Yes ☐ No ☐

Relationship to Applicant:

First Name

Last Name

Street Address

City State ZIP

b. 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 "YES," please provide the following information.	**Applicant** Yes ☐ No ☐	

Relationship to Applicant:

First Name

Last Name

Street Address

City State ZIP

Policy/Certificate Number

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

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

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	

Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

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

Policy forms UM1, UM2, UM3, UM4, UM5, UM6, UM7, UM8, UM9 or state equivalent.

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 _____

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
UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Please refer to instructions on back of this form.

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)

Applicant	**Spouse/Applicant B**
Indicate ☐ Checking Account or ☐ Savings Account	Indicate ☐ Checking Account or ☐ Savings Account
Bank Name	Bank Name
Routing Number (First 9 digits on the lower left hand side of check)	Routing Number (First 9 digits on the lower left hand side of check)
Account Number	Account Number
Is this a business account? ☐ Yes ☐ No	Is this a business account? ☐ Yes ☐ No

I authorize United of Omaha 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 $ _____ Initial Premium Payment Amount $ _____

Applicant	**Spouse/Applicant B**
Name as Shown on Account (please print)	Name as Shown on Account (please print)
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
Date	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.

Applicant	**Spouse/Applicant B**
Indicate ☐ Checking Account or ☐ Savings Account	Indicate ☐ Checking Account or ☐ Savings Account
Bank Name	Bank Name
Routing Number (First 9 digits on the lower left hand side of check)	Routing Number (First 9 digits on the lower left hand side of check)
Account Number	Account Number
Is this a business account? ☐ Yes ☐ No	Is this a business account? ☐ Yes ☐ No
Specify date of withdrawls: ☐ 1st of Month ☐ 15th of Month	Specify date of withdrawls: ☐ 1st of Month ☐ 15th of Month

I authorize you to pay and charge my account any checks, drafts or preauthorized electronic fund transfers made upon my account by, and payable to the order of, United of Omaha 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.

Applicant	**Spouse/Applicant B**
Name as Shown on Account (please print)	Name as Shown on Account (please print)
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
Date	Date

ACH Form Instructions

The applicant can choose to pay the initial premium via ACH, the initial premium by check and renewal premiums via ACH, or both the initial and renewal premiums via ACH.

- When choosing to **only pay the initial premium via ACH**, applicant must complete the **TOP PORTION** of form and submit the form with the application. Do not submit a check for payment, however, a voided check may be submitted in lieu of completing the account information (routing/account numbers) on the form.
- When choosing to pay the **initial premium by check and renewal premiums ACH**, applicant must complete the **BOTTOM PORTION** of form and submit a check for payment with the application.
- When choosing to pay **both the initial and renewal premiums via ACH**, applicant must complete the **TOP AND BOTTOM PORTIONS** of form. Do not submit a check for payment, however, a voided check may be submitted in lieu of completing the account information (routing/account numbers) on the form.

When the applicant chooses to pay their premium(s) via ACH, payment is charged to the applicant when the applicants account is received and entered into the system. Payment can not be postponed until a later date.

United of Omaha will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

United of Omaha does not accept payment from a third party, including any foundations.

Initial ACH Fax Transmittal Option

When a Medicare Supplement applicant chooses initial premiums to be paid via ACH, you have the convenience of faxing the application, Authorization to Withdraw Funds form **(U7535_0208)** and other necessary forms to United of Omaha using a **dedicated fax line**. Please use this **dedicated** fax line **only** for those Medicare supplement applications that include the Authorization to Withdraw Funds form **(U7535_0208)**.

- ACH Fax Transmittal Coversheet **(AFN41045)** is available for download on Sales Professional Access under *Forms and Materials*.
- **Dedicated fax number 402-351-1078.**
- Fax the forms **ONLY ONCE** and **DO NOT MAIL** hard copies of the application to United of Omaha.

Note: Sending the fax multiple times or mailing hard copies can cause multiple system entries and, potentially, multiple charges to the client. Please retain your fax confirmation sheet and the original forms for your own records.

United of Omaha Life Insurance Company

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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

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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, 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 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.

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.

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

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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.

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 United of Omaha Life 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 Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

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

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 premium 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*

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

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

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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 Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

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

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 premium 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*

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.