

MUTUAL OF OMAHA INSURANCE COMPANY

P.O. Box 3608 Omaha, Nebraska 68103-3608



**APPLICATION for
MEDICARE SUPPLEMENT INSURANCE**

NORTH CAROLINA

Med Supp e-App...to be sure



Try it today on Sales Professional Access
or contact Sales Support.

2013 Medicare Supplement Insurance Plans



*Spontaneous. **FUN!**Fearless.*

Whether you're six or sixty something, playing keeps you young-at-heart. The difference now, of course, is that you have adult responsibilities, including making sound financial decisions.

You'll probably enjoy playing, however you define it, even more when you feel you've got your bases covered.

A Medicare supplement insurance policy from Mutual of Omaha Insurance Company can help you attain that secure feeling.

With a Medicare supplement insurance policy, you

- *Keep your doctors and health care providers (as long as they accept Medicare patients)*
- *See specialists without referrals*
- *Receive benefits with no waiting period**
- *Enjoy guaranteed coverage for life**
- *Don't pay a policy fee with our plan*

Add our helpful midwestern customer service staff and affordable premiums – including a discount for your eligible spouse or household resident – and you have the financial value and security you seek.

**see details on back cover*

Underwritten by

MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza

Omaha, NE 68175

mutualofomaha.com

Mutual of Omaha Insurance Company is licensed nationwide.

We've got you covered. *GO PLAY!*

Select the Medicare Supplement Insurance Plan that's Right for You

	Medicare Pays	Plan A Pays	Plan F Pays	Plan G Pays
Medicare Part A Hospital Insurance*				
Deductible	Nothing		\$1,184	\$1,184
First 60 days	100%			
Coinsurance 61-90 days	All but \$296 a day	\$296 a day	\$296 a day	\$296 a day
Coinsurance 91-150 days	All but \$592 a day	\$592 a day	\$592 a day	\$592 a day
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	Nothing	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints
Skilled Nursing Facility Care				
First 20 days	100%			
Coinsurance 21-100 days	All but \$148 a day		Up to \$148 a day	Up to \$148 a day
Hospice Care				
Outpatient Prescription Drugs	All but \$5	\$5	\$5	\$5
Inpatient Respite Care	All but 5%	5% of Medicare's approved amount	5% of Medicare's approved amount	5% of Medicare's approved amount
Medicare Part B Medical Insurance*				
Deductible	Nothing		\$147	
Coinsurance	80%	20%	20%	20%
Excess Benefits			100% up to Medicare's limit	100% up to Medicare's limit
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints
Additional Benefit*				
Emergency Care Received Outside the U.S.	Nothing		80% to lifetime max of \$50,000	80% to lifetime max of \$50,000

* Refer to the next page and your outline of coverage for more information.

Your Premium
\$ _____

Your Premium
\$ _____

Your Premium
\$ _____

Medicare Part A Hospital Coverage

Medicare Part A hospital/skilled nursing facility care eligible expenses include charges for semiprivate room and board, general nursing and miscellaneous services and supplies.

Deductible – Plans F and G pay the \$1,184 inpatient hospital deductible for each benefit period, which begins the first full day you're hospitalized and ends when you haven't been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance – All plans pay \$296 a day when you're hospitalized from the 61st through the 90th day. And, when you're in the hospital from the 91st day through the 150th day, you receive \$592 a day for each Lifetime Reserve day used.

Extended Hospital Coverage – When you're in the hospital longer than 150 days during a benefit period, and you've exhausted your 60 days of Medicare Lifetime Reserve, all plans pay the Medicare Part A eligible expenses for hospitalization, paid at the rate

Medicare would have paid, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

Skilled Nursing Facility Care Benefit

Coinsurance – Plans F and G pay up to \$148 a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care Benefit

Outpatient Prescription Drugs – All plans pay \$5 per prescription for outpatient prescription drugs for pain and symptom management.

Inpatient Respite Care – All plans pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest).

Medicare Part B Medical Coverage

Medicare Part B eligible expenses include charges for physicians' services, hospital outpatient services and supplies, physical and speech therapy and ambulance service.

Deductible – Plan F pays the \$147 calendar-year deductible.

Coinsurance – After the Medicare Part B deductible, all plans pay 20% of eligible expenses. For hospital outpatient services, the copayment amount will be paid

under a prospective payment system. If this system is not used, then 20% of eligible expenses will be paid.

Excess Benefits – Your bill for Medicare Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Benefit for Blood – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

Additional Benefit

Emergency Care Received Outside the U.S. – After you pay a \$250 calendar-year deductible, Plans F and G pay you 80% of eligible expenses for health care you

need because of a covered injury or illness beginning during the first 60 days of each trip up to a lifetime maximum of \$50,000.

Plan Overview

Your Mutual of Omaha Medicare supplement insurance policy helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B.

There may be charges above what Medicare and Mutual of Omaha pay.

Your Medicare supplement insurance does not pay for:

- any expense incurred before your policy date
- hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force
- expense paid for by Medicare

- services for non-Medicare eligible expenses
- services for which no charge is made when there is no insurance
- loss or expense that is payable under any other Medicare supplement insurance policy or certificate

Medicare eligible expenses means charges of the kinds covered by Medicare Parts A and B, to the extent Medicare recognizes them as reasonable and medically necessary.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by Mutual of Omaha.

Features Give You More Peace of Mind

You're covered immediately. There is no waiting period for preexisting conditions and benefits will be paid from the time your policy is in force.

Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and the information is correct on your application.

Your Medicare supplement insurance benefits will automatically increase as Medicare deductibles and coinsurance increase. Benefits are not paid for any expense paid by Medicare.

Benefits are paid to you, your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay in force during this 31-day grace period.

You cannot be singled out for a rate increase, no matter how many times you receive benefits. Your premium changes: **(a) When Changed for All Policies Like Yours** – This can occur only when we make the same change for all policies for everyone within your classification that are renewed in the same geographic area of the state where you live at the time we change premium. Your premium will not increase for at least 12 months from the effective date of coverage, and future increases will not become effective for at least 12 months from the date of the last increase; **(b) At Attained Age** – Until you are age 99, your premium changes each year and will be based upon your age at that time. This change only will be made on the first renewal date that is on or next follows the policy anniversary date. Your policy's two-person household premium discount ends if the person you live with terminates his or her policy or moves to a different residence.



You can be confident that your Medicare supplement insurance benefits will be paid as promised because Mutual of Omaha Insurance Company has been serving people like you since Medicare began more than 40 years ago.

And, we're committed to continue providing Medicare supplement insurance benefits amid an ever-changing political and economic environment.

This is a brief description of your coverage. The outline of coverage must accompany this brochure. For complete information on benefits, exceptions, limitations and reductions, please read your outline of coverage and your policy. **CAUTION: POLICY BENEFITS ARE LIMITED TO THOSE APPROVED BY MEDICARE FOR PAYMENT.**

This is a solicitation of insurance and an insurance agent will contact you by telephone.

Neither Mutual of Omaha Insurance Company nor its Medicare supplement insurance policies are connected with or endorsed by the U.S. government or the federal Medicare program. Premiums are based on attained age, which means they increase each year with age. You have the right to obtain a copy of the NAIC Health & Human Services Guide to Health Insurance for People with Medicare.

MUTUAL OF OMAHA INSURANCE COMPANY
A Mutual of Omaha Company
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
BENEFIT PLANS A, F AND G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance*	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,800; paid at 100% after limit reached	Out-of-pocket limit \$2,400; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,110 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,110. Out-of-pocket expenses for this deductible are plans' separate foreign travel emergency deductible. These expenses include the Medicare deductibles for Part A and Part B, but do not include the

MONTHLY NON-TOBACCO PREMIUMS*
ZIP CODES: 270 - 289

FEMALE				MALE			
Plan A MM20	Plan F MM24	Plan G MM25	Attained Age	Plan A MM20	Plan F MM24	Plan G MM25	
322.37	454.04		Thru 64	364.25	513.04		
85.51	120.44	87.32	65	96.62	136.09	98.67	
85.51	120.44	87.32	66	96.62	136.09	98.67	
85.51	120.44	87.32	67	96.62	136.09	98.67	
88.13	124.12	89.99	68	99.57	140.25	101.68	
91.01	128.18	92.93	69	102.83	144.83	105.01	
93.89	132.24	95.87	70	106.09	149.42	108.33	
97.03	136.66	99.08	71	109.63	154.42	111.95	
100.17	141.08	102.29	72	113.19	159.42	115.58	
103.57	145.88	105.76	73	117.04	164.84	119.51	
106.98	150.67	109.24	74	120.88	170.25	123.43	
110.65	155.84	112.98	75	125.02	176.08	127.66	
114.31	161.00	116.72	76	129.16	181.92	131.89	
118.24	166.53	120.73	77	133.60	188.17	136.42	
122.16	172.06	124.74	78	138.04	194.42	140.95	
126.35	177.96	129.02	79	142.77	201.08	145.79	
130.54	183.86	133.30	80	147.51	207.75	150.62	
134.99	190.13	137.84	81	152.54	214.83	155.75	
139.44	196.39	142.39	82	157.56	221.92	160.89	
144.15	203.03	147.20	83	162.89	229.42	166.33	
148.87	209.67	152.01	84	168.21	236.92	171.77	
154.10	217.05	157.36	85	174.12	245.25	177.80	
159.60	224.79	162.97	86	180.34	254.00	184.15	
165.36	232.91	168.86	87	186.85	263.17	190.80	
171.12	241.02	174.74	88	193.36	272.33	197.44	
177.14	249.49	180.88	89	200.16	281.92	204.39	
183.16	257.98	187.04	90	206.97	291.50	211.34	
189.45	266.83	193.45	91	214.07	301.50	218.59	
195.73	275.68	199.86	92	221.17	311.50	225.84	
202.28	284.90	206.55	93	228.56	321.91	233.38	
208.82	294.12	213.23	94	235.96	332.33	240.94	
215.37	303.34	219.92	95	243.35	342.75	248.49	
222.17	312.92	226.87	96	251.05	353.58	256.35	
228.98	322.51	233.82	97	258.74	364.42	264.21	
235.79	332.10	240.77	98	266.43	375.25	272.05	
242.86	342.05	247.99	99+	274.42	386.50	280.21	

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

Mutual of Omaha Insurance Company
 North Carolina Plans A, F & G
 Life Expectancy* at Issuance and Increase**
 In Monthly Premium after 10 Policy Years

Age at Issue	Female Non-Tobacco			Male Non-Tobacco					
	Life Expectancy	Plan A	Plan F	Plan G	Age at Issue	Life Expectancy	Plan A	Plan F	Plan G
65	20.55	25.14	35.40	25.66	65	17.39	28.40	39.99	28.99
66	19.70	28.80	40.56	29.40	66	16.58	32.54	45.83	33.22
67	18.87	32.73	46.09	33.41	67	15.79	36.98	52.08	37.75
68	18.05	34.03	47.94	34.75	68	15.02	38.47	54.17	39.27
69	17.26	35.34	49.78	36.09	69	14.27	39.94	56.25	40.78
70	16.92	36.65	51.62	37.43	70	13.96	41.42	58.33	42.29
71	16.10	37.96	53.47	38.76	71	13.21	42.91	60.41	43.80
72	15.30	39.27	55.31	40.10	72	12.49	44.37	62.50	45.31
73	14.53	40.58	57.15	41.44	73	11.78	45.85	64.58	46.82
74	13.77	41.89	59.00	42.77	74	11.10	47.33	66.67	48.34
75	13.05	43.45	61.21	44.38	75	10.45	49.10	69.17	50.14
76	12.30	45.29	63.79	46.25	76	9.78	51.18	72.08	52.26
77	11.97	47.12	66.38	48.13	77	9.51	53.25	75.00	54.38
78	11.26	48.96	68.96	50.00	78	8.88	55.32	77.91	56.49
79	10.58	50.79	71.53	51.86	79	8.28	57.39	80.84	58.60
80	9.92	52.62	74.12	53.74	80	7.70	59.46	83.75	60.72
81	9.27	54.46	76.70	55.61	81	7.13	61.53	86.67	62.84
82	9.01	56.29	79.29	57.47	82	6.91	63.61	89.58	64.95
83	8.39	58.13	81.87	59.35	83	6.38	65.67	92.49	67.05
84	7.81	59.95	84.45	61.22	84	5.88	67.75	95.41	69.17
85	7.59	61.27	86.29	62.56	85	5.70	69.23	97.50	70.69
86	7.02	62.57	88.13	63.90	86	5.21	70.71	99.58	72.20
87	6.48	63.62	89.60	64.96	87	4.76	71.89	101.25	73.41
88	5.97	64.67	91.08	66.03	88	4.33	73.07	102.92	74.61
89	5.48	65.72	92.56	67.11	89	3.93	74.26	104.58	75.82
90+	5.01	59.70	84.07	60.95	90+	3.56	67.45	95.00	68.87

*Life expectancy includes only mortality

**Increase in premium is based on rates at the time of Issue. Increase is subject to premium change provisions.

MONTHLY TOBACCO PREMIUMS*
ZIP CODES: 270 - 289

FEMALE				MALE			
Plan A MM20	Plan F MM24	Plan G MM25	Attained Age	Plan A MM20	Plan F MM24	Plan G MM25	
348.50	490.85		Thru 64	393.79	554.63		
92.45	130.20	94.40	65	104.45	147.12	106.67	
92.45	130.20	94.40	66	104.45	147.12	106.67	
92.45	130.20	94.40	67	104.45	147.12	106.67	
95.27	134.18	97.28	68	107.65	151.62	109.93	
98.39	138.57	100.46	69	111.17	156.58	113.52	
101.50	142.96	103.64	70	114.69	161.54	117.11	
104.90	147.74	107.12	71	118.52	166.94	121.03	
108.29	152.52	110.58	72	122.36	172.34	124.95	
111.97	157.70	114.34	73	126.53	178.20	129.20	
115.65	162.89	118.10	74	130.68	184.06	133.44	
119.62	168.47	122.15	75	135.16	190.36	138.01	
123.58	174.05	126.19	76	139.64	196.67	142.58	
127.82	180.03	130.52	77	144.43	203.42	147.48	
132.07	186.01	134.86	78	149.23	210.18	152.38	
136.60	192.39	139.49	79	154.34	217.39	157.61	
141.12	198.77	144.11	80	159.47	224.60	162.83	
145.94	205.55	149.02	81	164.90	232.25	168.38	
150.74	212.32	153.93	82	170.33	239.91	173.93	
155.84	219.50	159.14	83	176.09	248.02	179.81	
160.94	226.67	164.34	84	181.85	256.13	185.69	
166.60	234.65	170.12	85	188.24	265.13	192.22	
172.54	243.02	176.18	86	194.96	274.60	199.08	
178.77	251.79	182.55	87	202.00	284.51	206.27	
185.00	260.56	188.90	88	209.03	294.41	213.45	
191.51	269.72	195.55	89	216.39	304.78	220.97	
198.02	278.90	202.20	90	223.75	315.14	228.47	
204.81	288.47	209.14	91	231.43	325.95	236.32	
211.60	298.03	216.07	92	239.10	336.76	244.15	
218.68	308.00	223.30	93	247.09	348.02	252.31	
225.75	317.96	230.52	94	255.09	359.28	260.48	
232.83	327.93	237.75	95	263.09	370.54	268.64	
240.19	338.30	245.27	96	271.40	382.25	277.13	
247.55	348.66	252.78	97	279.72	393.97	285.63	
254.91	359.03	260.30	98	288.03	405.68	294.11	
262.55	369.79	268.10	99+	296.67	417.84	302.93	

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

Mutual of Omaha Insurance Company
 North Carolina Plans A, F & G
 Life Expectancy* at Issuance and Increase**
 In Monthly Premium after 10 Policy Years

Age at Issue	Life Expectancy			Age at Issue			Life Expectancy			Male Tobacco		
	Plan A	Plan F	Plan G	Plan A	Plan F	Plan G	Plan A	Plan F	Plan G	Plan A	Plan F	Plan G
65	18.04	38.27	27.75	65	15.36	30.71	43.24	31.34				
66	17.22	43.85	31.79	66	14.59	35.19	49.55	35.91				
67	16.43	49.83	36.12	67	13.84	39.98	56.30	40.81				
68	15.65	51.83	37.58	68	13.12	41.58	58.56	42.45				
69	14.90	53.82	39.03	69	12.43	43.17	60.81	44.09				
70	14.56	55.81	40.47	70	12.11	44.78	63.06	45.72				
71	13.79	57.81	41.90	71	11.42	46.38	65.31	47.35				
72	13.04	59.80	43.35	72	10.76	47.97	67.57	48.98				
73	12.32	61.80	44.80	73	10.12	49.56	69.82	50.61				
74	11.63	63.78	46.24	74	9.50	51.17	72.07	52.25				
75	10.96	66.18	47.97	75	8.91	53.08	74.77	54.21				
76	10.27	68.97	49.99	76	8.32	55.32	77.93	56.50				
77	9.95	71.76	52.03	77	8.04	57.57	81.09	58.79				
78	9.31	74.55	54.04	78	7.49	59.80	84.23	61.07				
79	8.70	77.33	56.06	79	6.96	62.05	87.39	63.36				
80	8.11	80.13	58.09	80	6.47	64.28	90.54	65.64				
81	7.54	82.92	60.12	81	5.98	66.53	93.70	67.94				
82	7.28	85.71	62.14	82	5.76	68.77	96.85	70.22				
83	6.75	88.50	64.16	83	5.31	71.00	100.00	72.50				
84	6.25	91.29	66.18	84	4.89	73.24	103.15	74.79				
85	6.02	93.28	67.63	85	4.70	74.85	105.41	76.42				
86	5.54	95.28	69.09	86	4.30	76.44	107.65	78.05				
87	5.09	96.87	70.23	87	3.93	77.72	109.46	79.36				
88	4.67	98.47	71.40	88	3.58	79.00	111.27	80.66				
89	4.28	100.07	72.55	89	3.26	80.28	113.06	81.96				
90+	3.91	90.89	65.90	90+	2.97	72.92	102.70	74.46				

*Life expectancy includes only mortality

**Increase in premium is based on rates at the time of Issue. Increase is subject to premium change provisions.

Disclosures

Use this outline to compare benefits and premiums among policies.

Premium Information

We, Mutual of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 90, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon your policy date.

Premiums are based on attained age rating which means premiums increase as your age increases. Premiums that are based on issue age do not increase as your age increases. Policies on an issue age basis should be compared to policies on an attained age basis.

Risk Class Rating

If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as [Class I - 10%] or [Class II - 20%] higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

Household Premium Discount

You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other Medicare-eligible adults who own or are issued a Medicare supplement policy underwritten by us or our affiliates. The discounted premium will be priced 7% lower than the rates illustrated.

The policy's household premium discount will be removed if your spouse or other Medicare supplement policyholder chooses to terminate his or her Medicare supplement policy or he or she no longer resides with you (other than in the case of his or her death).

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it us at Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

The policy may not fully cover all of your medical costs. Neither Mutual of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,184	\$0	\$1,184 (Part A deductible)
61 st through 90 th day	All but \$296 a day	\$296 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$592 a day	\$592 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$148 a day	\$0	Up to \$148 a day
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

*Once you have been billed \$147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$147 of Medicare-approved amounts*	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$147 of Medicare-approved amounts*	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$147 of Medicare-approved amounts*	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLANS F AND G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,184	\$1,184 (Part A deductible)	\$0	\$1,184 (Part A deductible)	\$0
61 st through 90 th day	All but \$296 a day	\$296 a day	\$0	\$296 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$592 a day	\$592 a day	\$0	\$592 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.					
First 20 days	All approved amounts	\$0	\$0	\$0	\$0
21 st through 100 th day	All but \$148 a day	Up to \$148 a day	\$0	Up to \$148 a day	\$0
101 st day and after	\$0	\$0	All costs	\$0	All costs
BLOOD					
First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's/certificate's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

*Once you have been billed \$147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$147 of Medicare-approved amounts*	\$0	\$147 (Part B deductible)	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0	100%	\$0
BLOOD					
First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$147 of Medicare-approved amounts*	\$0	\$147 (Part B deductible)	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	\$0	\$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment First \$147 of Medicare-approved amounts*	\$0	\$147 (Part B deductible)	\$0	\$0	\$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0	20%	\$0

**PLANS F AND G
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
FOREIGN TRAVEL —NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	\$0	\$0	\$250	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit
Remainder of charges					

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period: (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:



- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan **Applicant A** _____

Applicant B _____



Before you begin: Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate.	65 51502		
#2	Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	Household Premium Discount Does a member of your household: (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married either have an existing Medicare supplement plan with, or are applying for coverage with, Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company? If yes , multiply the amount from Step #2 by .93. If no , enter the amount from Step #2.	\$128.52 x .93 = \$119.52 In this example, the person qualifies for the household premium discount.		
#4	Rate Adjustment <i>If you're in your open enrollment or guaranteed issue period, skip to Step #5.</i> Locate your height, then weight on the next page. <ul style="list-style-type: none"> If your weight is in the Standard column, enter the amount from Step #3 If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 1.20 if in Class II column 	\$119.52 x 1.20 = \$143.42 Person's weight is in the Class II column.		
#5	Payment Options Your monthly payment is your last premium entered (Step #3 or #4). 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		

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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	Standard	Class I	Class II	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

MUTUAL of OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza
Omaha, Nebraska 68175
mutualofomaha.com

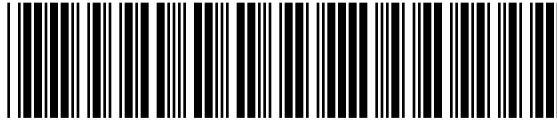


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Agent Writing # <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	FAV Key _____	Auth # _____	Group # (if applicable) _____	Keyline _____
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MUTUAL of OMAHA INSURANCE COMPANY



Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G	Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G
Requested Effective Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Requested Effective Date <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Deliver Policy to Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>	Deliver Policy to Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address (if different from Applicant A'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 <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>	State ZIP <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>
Home Phone <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <small>(area code)</small>	Home Phone <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <small>(area code)</small>
E-mail Address	E-mail Address
Current Age _____	Current Age _____
Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <small>mo day yr</small>	Date of Birth <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <small>mo day yr</small>
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Social Security # <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> - <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>
Height Weight Ft <input style="width: 20px;" type="text"/> In <input style="width: 20px;" type="text"/> Lbs <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>	Height Weight Ft <input style="width: 20px;" type="text"/> In <input style="width: 20px;" type="text"/> Lbs <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/>

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B. Applicant Information (continued)

Applicant A

Applicant B

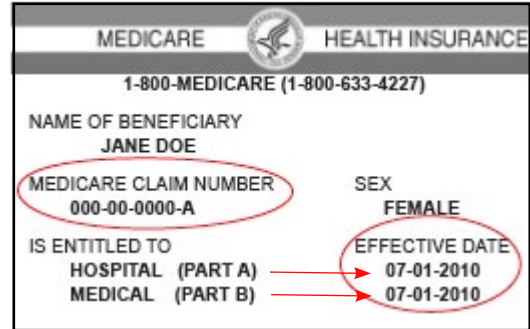
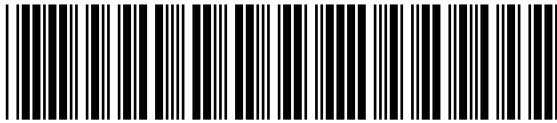
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Mutual of Omaha Insurance Company.

Receive statement online? Y N

Receive statement online? Y N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A

Applicant B

Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>
Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.

- Does a member of your household:
 - with whom you have continuously resided for the last 12 months; or
 - with whom you reside and to whom you are either married or in a civil union partnership; either have an existing Medicare supplement plan with, or are applying for coverage with Mutual of Omaha Insurance Company, Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?.....

Applicant A

Applicant B

Y N

Y N

- If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)
Policy Number
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:

	Applicant A	Applicant B
3. 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.) If "YES," answer the following about this existing coverage:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

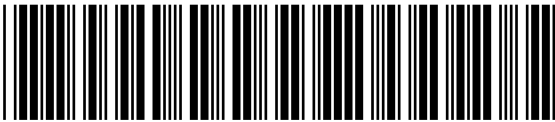
Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	Applicant A <input type="checkbox"/> Y <input type="checkbox"/> N	Applicant B <input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this previous or existing coverage:		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant A END <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B END <input type="text"/> / <input type="text"/> / <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Is your former Medicare supplement or Medicare Select policy certificate still available?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



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- (g) Please indicate reason for termination/disenrollment:
- Your Medicare Advantage plan is leaving the Medicare program.....
 - Your Medicare Advantage organization stopped offering Medicare Advantage plans.....
 - Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
 - You moved out of the geographic service area of your Medicare Advantage plan.....
 - You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....
 - Other: _____
Applicant A

 - Applicant B

Check box(s) below if applicable

Applicant A	Applicant B
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please answer questions regarding other health insurance:

6. Have you had coverage under any other health insurance within the past 63 days?.....
(For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

If "YES," answer the following about this previous or existing coverage:

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

Applicant A	START	/ /
	END	/ /
Applicant B	START	/ /
	END	/ /



(b) Planned date of termination/disenrollment?.....

Applicant A	/ /
Applicant B	/ /

(c) Have you disenrolled from your current coverage voluntarily?.....

<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
---	---

(d) Please state the reason for your disenrollment:

Applicant A

Applicant B

(e) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

7. Are you applying during a guaranteed issue period?.....
(NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible.
If the answer above is "YES," attach proof of eligibility.)
8. Did you turn age 65 in the last six months?.....
9. Did you enroll in Medicare Part B in the last six months?.....

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

If "YES," indicate your Medicare Part B effective date.....

Applicant A	/ /
Applicant B	/ /



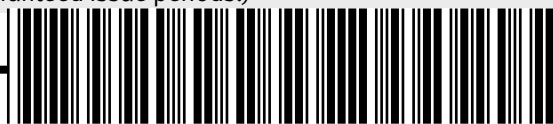
IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

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If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS G & H and GO TO SECTION I.

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information



For all plans, answer questions 10-21.

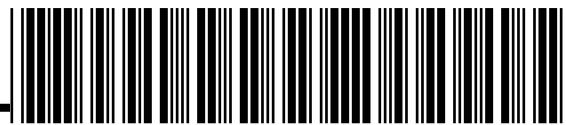
(If "YES" is answered to any of the following questions 10-19, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Are you currently receiving any occupational, speech or physical therapy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus, scleroderma or myasthenia gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have diabetes in addition to any of the following: retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, any heart disorder (including hypertension/high blood pressure), stroke, transient ischemic attack (TIA) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
19. Have you been hospital confined three or more times in the past two years for a same or similar condition?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
20. Have you taken any over-the-counter or prescription drugs in the past 24 months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
21. Have you used tobacco in any form in the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

(If YES, please complete the Medication Information sheet on the next page)

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H. Medication Information



If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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I. Agreement and Authorization



IMPORTANT STATEMENTS

- 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 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.
- 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.
- 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO Mutual of Omaha INSURANCE COMPANY

- I authorize any physician, 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, the group of companies which presently includes Mutual of Omaha Insurance Company, Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Mutual of Omaha Insurance Company. Unless revoked earlier, this authorization will remain in effect for 30 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. 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.
- "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, which are 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.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- 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.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I have the right to receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. 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 Mutual of Omaha Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

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

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

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METHOD OF PAYMENT FORM

Part I. Select Premium Payment Option

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

<p>Initial Premium Payment (Select option #1 or #2)</p> <p> Initial premium amount (based on age at application date).....</p> <p>1. Paper Check (submit signed check with application).....</p> <p>2. Automated Bank Account Withdrawal.....</p> <p>Ongoing Premium Payments (Select option #1 or #2)</p> <p>1. I want my payments automatically withdrawn from my bank account every month on (Circle date).....</p> <p>2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....</p>	<p>Applicant A</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1st or 15th every _____ months Insert 3, 6, or 12</p>	<p>Applicant B</p> <p>\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p>1st or 15th every _____ months Insert 3, 6, or 12</p>
--	---	---

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed in force, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is placed in force.**

Part II. Payor Information

<p>1. Account Owner Name, if different than applicant's.....</p> <p>2. If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.</p> <p style="padding-left: 40px;">Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)</p> <p style="padding-left: 40px;">Living Trust</p> <p style="padding-left: 40px;">Power of Attorney or legal guardian (documentation required)</p> <p style="padding-left: 40px;">Business owned by applicant or applicant's spouse</p>	<p>Applicant A</p> <p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Applicant B</p> <p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
---	--	--

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:

This section is intended as authorization to debit your bank account.

Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here	<p>Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Routing Number (9 digits on lower left side of check)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Account Number (Do NOT use Debit/Credit Card numbers)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Name as Shown on Account</p> <p>_____</p>	<p>Applicant B <input type="checkbox"/> Same account as Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Routing Number (9 digits on lower left side of check)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Account Number (Do NOT use Debit/Credit Card numbers)</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Name as Shown on Account</p> <p>_____</p>
-------------------------------------	--	---

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.





Example:

Account Holder Name	Do NOT include the check # in the Routing or Account Number.
John Doe Street Address Town, City ZIP Code	Check #1234 Date: _____
Pay to:	Dollars
Financial Institution Name & Address	Account Number
Memo:	Signed By: _____
1:123456789:1 12345678 11 1234 11	

M27784_0113

Part III. Account Information (continued)

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

Applicant A  _____ Authorized Signature as Shown on Account _____ Date	Applicant B  _____ Authorized Signature as Shown on Account _____ Date
--	--





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. The replacement of insurance involved in this transaction does not duplicate coverage to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

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

1. Health conditions which you may now have (preexisting conditions) may not be immediately or fully covered under the new policy if you have had your present policy for less than six months.
2. 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*

Date

MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

M18362_NC

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Premium Receipt / Notice of Information Practices



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. The replacement of insurance involved in this transaction does not duplicate coverage to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

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

1. Health conditions which you may now have (preexisting conditions) may not be immediately or fully covered under the new policy if you have had your present policy for less than six months.
2. 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* _____
Date
 MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

M18362_NC

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

Premium Receipt

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

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

Applicant A

Received from _____
this ____ day of _____, _____
an application for Form _____ Policy
and/or Riders _____ and _____
Check for _____ Dollars.

Applicant B

Received from _____
this ____ day of _____, _____
an application for Form _____ Policy
and/or Riders _____ and _____
Check for _____ Dollars.

 Agent _____

 Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Mutual of Omaha Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.



Notice of Information Practices

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

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

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

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

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

Provide the completed premium receipt, if applicable, and notice to the applicant.