

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, D, G, High Deductible G, 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, D, G, High Deductible G, 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 A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility:

- Copy of the applicant's MA plan's termination notice
- Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- Certification of group coverage
- Copy of the termination letter from employer or group carrier
- Image of insurance ID card (**ONLY** allowed if your MA plan is being terminated)
- Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan Applicant A _____

Applicant B _____

	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 Please refer to the application for state specific household premium discount rules. If the rules apply , multiply the amount from Step #2 by .88. If the rules do not apply , enter the amount from Step #2.	$\$128.52 \times .88 =$ \$113.10 In this example, the person qualifies for the household premium discount.		
#4	Payment Options Your monthly payment is your last premium entered (Step #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)	\$113.10 monthly payment \$339.30 quarterly payment \$678.6 semiannual payment \$1,357.20 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.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	55 - 145	146 +
4' 3"	< 56	57 - 151	152 +
4' 4"	< 58	59 - 157	158 +
4' 5"	< 60	61 - 163	164 +
4' 6"	< 63	64 - 170	171 +
4' 7"	< 65	66 - 176	177 +
4' 8"	< 67	68 - 182	183 +
4' 9"	< 70	71 - 189	190 +
4' 10"	< 72	73 - 196	197 +
4' 11"	< 75	76 - 202	203 +
5' 0"	< 77	78 - 209	210 +
5' 1"	< 80	81 - 216	217 +
5' 2"	< 83	84 - 224	225 +
5' 3"	< 85	86 - 231	232 +
5' 4"	< 88	89 - 238	239 +
5' 5"	< 91	92 - 246	247 +
5' 6"	< 93	94 - 254	255 +
5' 7"	< 96	97 - 261	262 +
5' 8"	< 99	100 - 269	270 +
5' 9"	< 102	103 - 277	278 +
5' 10"	< 105	106 - 285	286 +
5' 11"	< 108	109 - 293	294 +
6' 0"	< 111	112 - 302	303 +
6' 1"	< 114	115 - 310	311 +
6' 2"	< 117	118 - 319	320 +
6' 3"	< 121	122 - 328	329 +
6' 4"	< 124	125 - 336	337 +
6' 5"	< 127	128 - 345	346 +
6' 6"	< 130	131 - 354	355 +
6' 7"	< 134	135 - 363	364 +
6' 8"	< 137	138 - 373	374 +
6' 9"	< 140	141 - 382	383 +
6' 10"	< 144	145 - 392	393 +
6' 11"	< 147	148 - 401	402 +
7' 0"	< 151	152 - 411	412 +
7' 1"	< 155	156 - 421	422 +
7' 2"	< 158	159 - 431	432 +
7' 3"	< 162	163 - 441	442 +
7' 4"	< 166	167 - 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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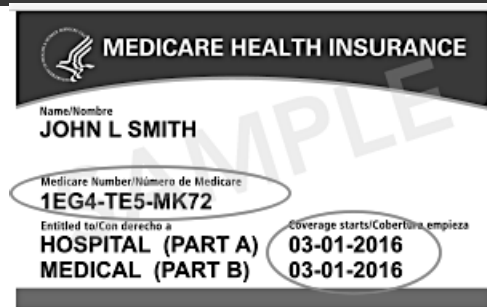
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B. Applicant Information (Continued - Must be completed in ink!)

Applicant A	Applicant B
<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"/>
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? <input type="checkbox"/> Y <input type="checkbox"/> N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? <input type="checkbox"/> Y <input type="checkbox"/> N
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 <u>not</u> 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.	
Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N	Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A 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"/> <input style="width:20px;" type="text"/>	Medicare Part A 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"/> <input style="width:20px;" type="text"/>
If you are not covered under Medicare Part A, what is your eligibility 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"/> <input style="width:20px;" type="text"/>	If you are not covered under Medicare Part A, what is your eligibility 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"/> <input style="width:20px;" type="text"/>
Medicare Part B 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"/> <input style="width:20px;" type="text"/>	Medicare Part B 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"/> <input style="width:20px;" type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <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"/>	If you are not covered under Medicare Part B, indicate the date you plan to enroll <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"/>

D. Household Premium Discount Information

	Applicant A	Applicant B
You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.		
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months and who is age 60 or older; or (b) with whom you reside and to whom you are either married or have a declaration of Domestic Partnership filed at the Secretary of State?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.		
Name (First/Middle/Last)		
Date of Birth		
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 such as open enrollment, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:

3. Are you covered for medical assistance through the state Medicaid or Medi-Cal program?...
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)

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

(a) Will Medicaid or Medi-Cal pay your premiums for this Medicare supplement policy?

(b) Do you receive any benefits from Medicaid or Medi-Cal OTHER THAN payments

toward your Medicare Part B premium?

Applicant A

Y N

Applicant B

Y N

Y N

Y N

Y N

Y N

Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement insurance policy or certificate or health care service plan in force?

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

(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?

(b) Indicate planned termination or disenrollment date.....Applicant A

Applicant B

(c) With what company, and what plan do you have?

Y N

Y N

Y N

Y N

____/____/____

____/____/____

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan
Effective Date	Effective Date

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).....

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 B START

END

END

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

(c) Planned date of termination/disenrollment?..... Applicant A

Applicant B

(d) Was this your first time in this type of Medicare plan?

(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?

(f) Is your former Medicare supplement or Medicare Select policy/certificate still available?

Applicant A

Y N

Applicant B

Y N

____/____/____

____/____/____

____/____/____

____/____/____

Y N

Y N

____/____/____

____/____/____

Y N

Y N

Y N

Y N

Y N

Y N

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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 10-22.



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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
12. Are you currently receiving any occupational, speech or physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
13. Within the past two years, have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow-up visits or surgery for any medical condition that has not been performed?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
14. Within the past five years 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alzheimer's Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Systemic Lupus, scleroderma or Myasthenia Gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
15. Within the past five, years have you been treated for 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
16. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
20. Have you used tobacco in any form in the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
(If answered "No," you will be eligible for a discount on your premium)		
21. 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
(If YES, please complete the Medication Information sheet on the next page)		
22. Applicant A (Height) Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		
Applicant B (Height) Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		

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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 the past 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 the past 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 or Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid or Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid or Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid or Medi-Cal. If you are no longer entitled to Medicaid or Medi-Cal, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid or Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the 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 Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free telephone number (1-800-927-HELP), your local HICAP office, or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).




I. Agreement and Authorization (cont.)


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, employers, consumer reporting agencies, and insurance companies to disclose Personal Information about me to Mutual of Omaha Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 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 and any information derived because of it 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 will 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)



Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)	Applicant A	Applicant B
<p> Initial premium amount (based on age at application date)..... \$ <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="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="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>1. Paper Check (submit signed check with application)..... (California collect only one month's premium at time of application)</p> <p>2. Automatic Bank Account Withdrawal.....</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
<p>Ongoing Premium Payments (Select option #1a, #1b, or #2)</p> <p>1. I want my payments automatically withdrawn from my bank</p> <p>a. Choose the day payments will be deducted every month from your bank account.....</p> <p style="text-align: center;">OR</p> <p>b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)</p>	<p>1st through the 28th or the last day of every month</p> <p>_____</p> <p>Week (1st, 2nd, 3rd, 4th, last)</p> <p>_____</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri) _____</p>	<p>1st through the 28th or the last day of every month</p> <p>_____</p> <p>Week (1st, 2nd, 3rd, 4th, last)</p> <p>_____</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri) _____</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>every _____ months Insert 3, 6, or 12</p>	<p>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(s) will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

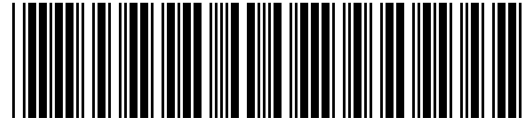
Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.

Part II. Payor Information

	Applicant A	Applicant B
<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. Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) Living Trust Power of Attorney or legal guardian (documentation required) Business owned by applicant or applicant's spouse</p>	<p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>_____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>



MUTUAL OF OMAHA INSURANCE COMPANY



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

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


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



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

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

Applicant	Applicant B
_____ Additional benefits that are: _____	_____ Additional benefits that are: _____
_____ No change in benefits, but lower premiums	_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums	_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D	_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
_____ Other reasons specified here: _____ _____	_____ Other reasons specified here: _____ _____

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

 _____
Signature of Agent, Broker or Other Representative* **Date**
MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature 	Signature 
Date	Date

*Signature not required for direct response sales.

M18362_CA



Guaranteed Issue and Open Enrollment Notice for California

Eligibility for Guaranteed Issue

During guaranteed issue, we must sell you one of the required Medicare Supplement policies at the best price for your age, without a waiting period or medical underwriting. If you answer YES to any of the following questions, you may be eligible for guaranteed issue:

1. Has your employer-sponsored retiree plan that is supplementing Medicare involuntarily terminated?
2. Has your employer-sponsored retiree plan stopped providing Medicare supplement benefits or the Medicare Part B 20% coinsurance for services?
3. Have you lost eligibility for an employer-sponsored retiree plan due to divorce or death of a spouse or family member?
4. Has your Medicare Advantage (MA) plan increased your premium or copayments by 15% or more, reduced your benefits, or terminated its relationship with your medical provider who was treating you?
5. Have you moved out of the area of your MA plan or Program for All-Inclusive Care for the Elderly (PACE) organization?
6. Has your MA plan, Medicare SELECT Plan, PACE provider or any other health plan under contract with Medicare: (a) committed fraud; (b) ended or lost its contract with Medicare; (c) misrepresented the plan you bought, or (d) failed to meet its contractual obligations to Medicare beneficiaries, as determined by the federal government?
7. Did you join a MA plan or PACE organization when you first became eligible for Medicare at age 65, and you want to switch to a Medicare Supplement policy during your first 12 months in the MA plan or PACE organization?
8. Have you switched from a Medicare Supplement policy to a MA plan, PACE organization, Medicare SELECT plan, or any other health care organization contracting with Medicare, for the first time since becoming eligible for Medicare within the past 12 months?
9. Has your MA plan left your area, and if so, did your MA plan benefits end within the past 123 days?

Eligibility for Open Enrollment

During open enrollment, you have the right to receive one of the required Medicare Supplement policies at the best price for your age, without medical underwriting. If you answer YES to any of the following questions, you may be eligible for open enrollment:

1. Did you turn age 65 within the last six months?
2. Did you enroll in Medicare Part B, at age 65 or older, within the last six months?
3. Will your plan effective date be within six months after turning age 65 and enrolling in Medicare Part B?
4. Are you under age 65, do not have End Stage Renal Disease (ESRD), and have Medicare Part B coverage that has been effective for six months or less?
5. Are you under age 65, do not have End Stage Renal Disease (ESRD), and received retroactive notice of your eligibility for Medicare within the past six months?
6. Have you lost an employer-sponsored health plan within the last six months?
7. Was your Medicare supplement coverage cancelled within the last six months because your residence changed to a location not serviced by your plan?
8. Are you a military retiree or spouse of a retiree, and within the last six months were your health care services cancelled due to a base closure, because the base no longer offers services, or because you relocated?
9. Have you lost Medi-Cal within the last six months due to an increase in your income or assets?
10. Are you enrolling during your annual 30-day birthday open enrollment period that begins on your birthday and replacing a Medicare supplement plan?

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



Agent's Signature

Date

M28410_CA

Applicant	Applicant B
Signature 	Signature
Date	Date

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

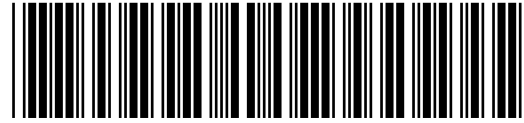
If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Guaranteed Issue and Open Enrollment Notice

24-Hour Meeting Notice

Premium Receipt / Notice of Information Practices

MUTUAL OF OMAHA INSURANCE COMPANY



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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



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

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

Applicant	Applicant B
_____ Additional benefits that are: _____	_____ Additional benefits that are: _____
_____ No change in benefits, but lower premiums	_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums	_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D	_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
_____ Other reasons specified here: _____ _____	_____ Other reasons specified here: _____ _____

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

 _____
Signature of Agent, Broker or Other Representative* **Date**
 MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature 	Signature 
Date	Date

*Signature not required for direct response sales.

M18362_CA



Guaranteed Issue and Open Enrollment Notice for California

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2. Has your employer-sponsored retiree plan stopped providing Medicare supplement benefits or the Medicare Part B 20% coinsurance for services?
3. Have you lost eligibility for an employer-sponsored retiree plan due to divorce or death of a spouse or family member?
4. Has your Medicare Advantage (MA) plan increased your premium or copayments by 15% or more, reduced your benefits, or terminated its relationship with your medical provider who was treating you?
5. Have you moved out of the area of your MA plan or Program for All-Inclusive Care for the Elderly (PACE) organization?
6. Has your MA plan, Medicare SELECT Plan, PACE provider or any other health plan under contract with Medicare: (a) committed fraud; (b) ended or lost its contract with Medicare; (c) misrepresented the plan you bought, or (d) failed to meet its contractual obligations to Medicare beneficiaries, as determined by the federal government?
7. Did you join a MA plan or PACE organization when you first became eligible for Medicare at age 65, and you want to switch to a Medicare Supplement policy during your first 12 months in the MA plan or PACE organization?
8. Have you switched from a Medicare Supplement policy to a MA plan, PACE organization, Medicare SELECT plan, or any other health care organization contracting with Medicare, for the first time since becoming eligible for Medicare within the past 12 months?
9. Has your MA plan left your area, and if so, did your MA plan benefits end within the past 123 days?

Eligibility for Open Enrollment

During open enrollment, you have the right to receive one of the required Medicare Supplement policies at the best price for your age, without medical underwriting. If you answer YES to any of the following questions, you may be eligible for open enrollment:

1. Did you turn age 65 within the last six months?
2. Did you enroll in Medicare Part B, at age 65 or older, within the last six months?
3. Will your plan effective date be within six months after turning age 65 and enrolling in Medicare Part B?
4. Are you under age 65, do not have End Stage Renal Disease (ESRD), and have Medicare Part B coverage that has been effective for six months or less?
5. Are you under age 65, do not have End Stage Renal Disease (ESRD), and received retroactive notice of your eligibility for Medicare within the past six months?
6. Have you lost an employer-sponsored health plan within the last six months?
7. Was your Medicare supplement coverage cancelled within the last six months because your residence changed to a location not serviced by your plan?
8. Are you a military retiree or spouse of a retiree, and within the last six months were your health care services cancelled due to a base closure, because the base no longer offers services, or because you relocated?
9. Have you lost Medi-Cal within the last six months due to an increase in your income or assets?
10. Are you enrolling during your annual 30-day birthday open enrollment period that begins on your birthday and replacing a Medicare supplement plan?

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



Agent's Signature

Date

M28410_CA

Applicant	Applicant B
Signature 	Signature
Date	Date

MUTUAL OF OMAHA INSURANCE COMPANY

Dear _____

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

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

A sales presentation on:

- Life insurance
- Annuities
- OTHER insurance _____

In Addition:

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

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

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

The following individuals will be coming to your home:

Name License #

Name License #

Sincerely,



Mutual of Omaha Insurance Company Representative

Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company

Health Insurance Underwritten by Mutual of Omaha Insurance Company

Both at Mutual of Omaha Plaza, Omaha NE, 68175

M28411_CA

M28411_CA



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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.

Agent _____

Applicant B

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

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, 3300 MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

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