Complete the Method of Payment form and return with the completed application

Complete Replacement Notice and leave a copy with the applicant (if applicable)

Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant

Note: An interviewer may call to verify/confirm the information provided on the application.

This form is required if splitting commissions.

Use premium determined by the **Calculate Your Premium form** One month's premium is collected at the time of application

Complete Senior 24-hour meeting Notice and leave with the applicant

with Notice of Information Practices

AP620 CA 0220

MAP620_CA_0220



Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan App	plicant A
••	plicant B

Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
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		
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		
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 x .88 = \$113.10 In this example, the person qualifies for the household premium discount.		
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 appual		
	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate. 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. 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. 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)	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate. 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. 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. 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) 65 65 65 65 65 61 65 65 65 65	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate. 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. 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. 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) S1502 \$128.52 \$128.52 x .88 = \$113.10 In this example, the person qualifies for the household premium discount.



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*



	FAV Key Auth #
Agent Writing #	Group # (if applicable) Keyline
MUTUAL OF OMAHA INSURANCE COMPANY Application for Medicare Supplement Covera	1
or shared with the other applicant.	pplicant on this application, all information provided may be viewed
A. Plan Information (to be completed by Pro Applicant A	Applicant B
Plan (select one): Plan A Plan G	Plan (select one): Plan A Plan G
High Deductible Plan G Plan N	High Deductible Plan G Plan N
OR If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: Plan F Plan F - High Deductible	OR If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: Plan F Plan F - High Deductible
Requested Effective Date	Requested Effective Date / / / / / / / / / / / / / / / / / / /
Deliver Policy to Applicant A Producer B. Applicant Information (Must be completed)	Deliver Policy to Applicant B Producer
Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Phone	Phone
E-mail Address	E-mail Address

Current Age

Current Age

City/State/ZIP

E. Previous or Existing Coverage Information

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: Applicant A Applicant B $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$ 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: $\square_{\mathsf{Y}} \square_{\mathsf{N}}$ $\prod_{Y}\prod_{N}$ (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 \square Y \square N \square Y \square N toward your Medicare Part B premium?..... Please answer questions regarding another Medicare supplement or Select plan: 4. Do you have another Medicare supplement insurance policy or certificate or health care $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$ 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? 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): Applicant A Applicant B 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)..... $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$ 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" blankApplicant A START Applicant B START FND (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?..... IY I IN (f) Is your former Medicare supplement or Medicare Select policy/certificate still available? $\square_{\mathsf{Y}} \square_{\mathsf{N}}$ $\square_{\mathsf{Y}} \square_{\mathsf{N}}$

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for

(g) Please indicate reason for termination/disenrollment Your Medicare Advantage plan is leaving the Medica Your Medicare Advantage organization stopped offer Your Medicare Advantage organization stopped offer in which you live	ing Medicare Advantage plans
Applicant B	
Please answer questions regarding other health insura	ance:
6. Have you had coverage under any other health insuranc (For example, an employer group health plan, union plar supplement plan.) If "YES," answer the following about this previous or exis (a) What are your dates of coverage under the other policy of you are still covered under this plan, leave "END" blan	sting coverage: y/certificate?
	END
(b) Planned date of termination/disenrollment?	Applicant B // // // // // // // // // // // // /
(d) Please state the reason for your disenrollment: Applicant A Applicant B	
(e) With what company and what kind of policy/certific	ate? (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 To the Best of Your Knowledge and Belief: 7. Are you applying during a guaranteed issue period? (NOTE: Refer to Section J of this application to help identify if you a	Applicant A Applicant B
eligibility if in a guaranteed issue period.) 8. Did you turn age 65 in the last six months?	
9. Did you enroll in Medicare Part B in the last six months?	
If "YES," indicate your Medicare Part B effective date	Applicant A///Applicant B////
STOP OTHERWISE IN AN OPEN ENROLLMENT P	R BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE ERIOD, SKIP SECTIONS G & H AND GO TO SECTION I. LICATION TO HELP IDENTIFY IF YOU ARE ELIGIBLE)

MA20966-04 Rev

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 with Yes(Y), No (N), or Not Sure (NS).

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?	□ Y □ N □ NS	□ Y □ N □ NS
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	$\square_{Y}\square_{N}\square_{NS}$	
12. Are you currently receiving any occupational, speech or physical therapy?	Y N N 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?	□Y□N□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?	\square Y \square N \square NS	
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic		
pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	Y N NS	H Y H N H NS
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's		
Disease)? E. Systemic Lupus, scleroderma or Myasthenia Gravis?		
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?		HYHNHNS
California law prohibits an HIV test from being required or used	LY L N L NS	L Y L N L NS
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)?	Y N NS	Y N NS
I. Osteoporosis with fractures?		HY HN HNS
15. Within the past five years, have you been treated for diabetes in addition to any of the	LY L N L NS	L Y L N L NS
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?	\square Y \square N \square NS	
16. Do you have an implanted cardiac defibrillator?	□ Y □ N □ NS	Y N 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?	\square Y \square N \square NS	\square Y \square N \square NS
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?		
C. Alcoholism or drug abuse?	Y N NS	
D. Any mental or nervous disorder requiring treatment (including hospital confinement)		
by a psychiatrist, psychologist, counselor or therapist?		
F. A stroke or transient ischemic attack (TIA)?	Y N NS	Y N 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?	\square \square \square \square \square \square \square \square \square	
18. Have you been advised by a medical professional that surgery may be required within		
the next 12 months for cataracts?	LY L N L NS	L Y L N L NS
or similar condition?	\square Y \square N \square NS	□ Y □ N □ NS
20. Have you used tobacco in any form in the past 12 months?(If answered "No," you will be eligible for a discount on your premium)	□ y □ n □ ns	□ y □ N □ NS
21. Have you taken any over-the-counter or prescription drugs in the past 24 months?	□ Y □ N □ NS	□ Y □ N □ NS
22. Applicant A (Height) Ft In (Weight) Lbs NS	5	
	•	
Applicant B (Height) Ft In (Weight) Lbs NS)	



If you are applying for <u>ANY</u> plan <u>OUTSIDE</u> 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. If you are unsure of the answer, do not know how to respond, or do not understand the question you may select "Not Sure" or "NS" or state "Not Sure" or "NS" in the space provided.

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
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□N□NS	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
			□y□n□ns	□Y□N□NS	
	•				
Applicant B					
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
Medication Name	Dosage	Frequency	this medication for more than the	by Primary	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years?	by Primary Physician?	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years?	by Primary Physician? Y N N NS Y N NS	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years? YNNNNS	by Primary Physician? YNNNNS YNNNNS YNNNNS	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years? YNNNNS YNNNS YNNNNS	by Primary Physician? YNNNNS YNNNNS YNNNNS YNNNNS	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years? YNNNNS YNNNS YNNNNS YNNNNS	by Primary Physician? YNNNNS YNNNNS YNNNNS YNNNNS YNNNNS	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years? YNNNNS YNNNS YNNNS YNNNS YNNNS YNNNS YNNNS YNNNS	by Primary Physician? YNNNNS YNNNNS YNNNNS YNNNNS YNNNNS	Diagnosis/Condition
Medication Name	Dosage	Frequency	this medication for more than the past 2 years? YNNNNS YNNNS YNNNS YNNNS YNNNS YNNNS YNNNS YNNNS	by Primary Physician? YNNNNS YNNNS YNNNS YNNNS YNNNS YNNNS YNNNS	Diagnosis/Condition

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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the 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).

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.



MA20966-04 Re

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/		J
City	State	Month Day	Year	Applicant B's Signature (if applying)



. Guaranteed Issue and Open Enrollment

Eligibility for Guaranteed Issue

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits or the Medicare Part B 20% coinsurance for services to the individual.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and the plan reduces any of its benefits or increases the amount of cost sharing or premium or discontinues (for other than good cause relating to the quality of care) its relationship or contract under the plan with a provider who is currently furnishing services to the individual.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by the same insurance company, a subsidiary of the same parent company, or a network that contracts with the insurance company's parent company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by the same insurance company, a subsidiary of the same parent company, or a network that contracts with the insurance company's parent company.

Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and premiums or copayments increase by 15% or more, benefits are reduced, or the provider contract is terminated with the medical provider treating the individual.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, material misrepresentation, or other involuntary termination of coverage.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advatage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment.

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.



I. Guaranteed Issue and Open Enrollment (Cont.)

Eligibility for Guaranteed Issue (Cont.)

Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy.

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.

Documentation of these events must be submitted with this Application. You must also apply within 63 days of the date of termination or the date you are notified of termination of previous coverage in order to qualify as an eligible person.

Eligibility for Open Enrollment

The following are requirements for individuals who are eligible for open enrollment:

Age 65 or over

If you are age 65 or over and eligible for Medicare, you have a six month period during which you can purchase any Medicare supplement policy available from any insurer at the lowest price for your age, even if you have or recently had health problems. Your six month open enrollment period starts the date your Medicare Part B coverage becomes effective. To avoid a gap in coverage you can apply for a Medicare supplement policy before the effective date of your Part B coverage and request that the policy begin on the same day as your Medicare benefits.

Under Age 65

If you are younger than age 65 and have Medicare because of a disability (not End-Stage Renal Disease), you have open enrollment rights for six months after the effective date of your Medicare Part B coverage. If you are notified retroactively of your eligibility for Medicare, your open enrollment period begins from the date of the notice of eligibility. To avoid a gap in coverage, you may request that the Medicare supplement policy becomes effective on the same day as your Medicare benefits.

- If Medicare Part A eligibility date is before 01/01/2020, you have the right to purchase Plans A, B, C, F, High Deductible Plan F, or N if currently available.
- If Medicare Part A eligibility date is on or after 01/01/2020, you have the right to purchase Plans A, B, D, G, High Deductible Plan G, or N if currently available.

If you became eligible for Medicare when you were younger than 65, you are also entitled to a six month open enrollment period on your 65th birthday, regardless of any health condition you may have, including End Stage Renal Disease. If you already have a Medicare supplement policy, you can keep it and request a lower premium because you are age 65, or you can switch to another Medicare supplement policy that better suits your needs. At age 65 you have the right to purchase any Medicare supplement policy available from any company.

Additional Open enrollment rights

An individual enrolled in Medicare Part B is entitled to the described open enrollment for six months following:

- Receipt of a notice of termination or, if no notice is received, the effective date of termination from an employer sponsored health plan including an employer sponsored retiree health plan.
- Receipt of a notice of loss of eligibility due to the divorce or death of a spouse, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse from any employer-sponsored health plan inlcuding an employer sponsored retiree health plan.
- Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a
 result of a military base closure or loss of access to health care services because the base no longer offers services or
 because the individual relocates.
- An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan
- An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, they only meet one of the following requirements: (1) they are no longer eligible for Medi-Cal benefits, or (2) they are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

If you are Under 65:

- If Medicare Part A eligibility date is before 01/01/2020, you have the right to purchase Plans A, B, C, F, High Deductible Plan F, or N if currently available.
- If Medicare Part A eligibility date is on or after 01/01/2020, you have the right to purchase Plans A, B, D, G, High Deductible Plan G, or N if currently available.

If you are Over 65 you can purchase any plan available. Plans C, F, and High Deductible F are available only if your Medicare Part A eligibility date is before 01/01/2020.

An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

K. To be Completed by Producer

23. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s). (a) List policies/certificates sold to the applicant(s) which are still in force. Applicant A **Applicant B** (b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force. Applicant A **Applicant B** I/We certify as follows: I/We have accurately recorded in the application the information supplied by the applicant(s)..... I/We certify that we have interviewed the proposed applicant(s)...... If you answered "NO" to any of the above statements, please explain why. I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice. To the best of my knowledge, the information on the application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I willfully state as true, any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars. Signature of Licensed Producer Signature of Licensed Producer Date Printed Name Printed Name Agent Writing Number Agent Writing Number



METHOD OF PAYMENT FORM

REQUIRED FORM - PLEASE RETURN PAGES 1 & 2

Part I. Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)	Applicant A	Applicant B
Initial premium amount (based on age at application date)	. \$	\$
1. Paper Check (submit signed check with application)	. 🗆	
(California collect only one month's premium at time of application)		
2. Automatic Bank Account Withdrawal		
Ongoing Premium Payments (Select option #1a, #1b, or #2)	1 st through the 28 th or	1 St through the 28 th or
I want my payments automatically withdrawn from my bank a. Choose the day payments will be deducted every month from your bank account	the last day of every month	the last day of every month
OR	Week (1 st , 2 nd , 3 rd , 4 th , last)	Week (1 st , 2 nd , 3 rd , 4 th , last)
b. Choose the week and weekday that payments will be		
deducted every month from your bank account (For Example: 3rd Wednesday of every month)	Weekday (Mon, Tue, Wed, Thu, Fri)	Weekday (Mon, Tue, Wed, Thu, Fri)
I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing)	everymonths Insert 3, 6, or 12	everymonths Insert 3, 6, or 12
When choosing automatic bank account withdrawal, MONEY WILL BE NOLICY APPROVAL AND ISSUE. The first withdrawal date may be differ Depending on the amount of time elapsed between the policy date and to ongoing withdrawal may exceed one modal premium and may occur on a not receive premium billing notices while on this premium payment optic banks. Each month, payments will be automatically deducted from the account premiums will be deducted on the policy date (which is determined at the	rent from the monthly date select he date the policy is placed information date other than the policy date on. We CANNOT establish elect below on the day selected above	ted for ongoing premiums. rce, the amount of the first The Proposed Insured(s) will tronic payments from foreign e. If no date is selected,
Ongoing deductions will begin once the policy is issued. If the scheduled will process on the following business day. Part II. Payor Information	l deduction date begins on a we	ekend or holiday, the payment
die in Fayor information	Applicant A	Applicant B
Account Owner Name, if different than applicant's		
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		
	l	



Part III. Account Information

rartini. Account iniormation	
Complete the Following ONLY if <u>Automated Bank Account V</u> This section is intended as authorization to debit your bank account Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach a copy of the Complete bank account information below OR attach account information below OR attach account information below OR attach account information account information below OR attach account information below OR attach account information accou	ount.
Applicant A Account Type (check one): Checking Savings Name of Financial Institution Routing Number (9 digits on lower left side of check) Account Number (Do NOT use Debit/Credit Card numbers) Name as Shown on Account	Applicant B Same account as Applicant A Account Type (check one): Checking Savings Name of Financial Institution Routing Number (9 digits on lower left side of check) Account Number (Do NOT use Debit/Credit Card numbers)
Payments cannot be postponed until a later date.	Account Holder Name Do NOT include the check # in the Routing or Account Number.
I authorize Mutual of Omaha Insurance Company ("Mutual of Omah monthly renewal premiums and understand that the amounts may despecifically revoked by me. Premium shortages may result from a variety my financial institution to pay from my account to Mutual of Omaha my financial institution shall be fully protected in honoring any such payment shall be the same as if the payment were signed personally in my account information. This authorization will be effective until is given verbally, Mutual of Omaha may require written confirmation.	differ. This authorization shall apply to any future payments unless ety of causes, including underwriting adjustments. I authorize any preauthorized bank account withdrawals. I agree that payment and that its rights and responsibilities regarding the by me. I agree to notify the business in writing of any changes I give you at least three business days' notice to cancel. If notice
Applicant A	Applicant B
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
Date	Date

Page 2



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:

change in benefits, but lower premiums
-
wer benefits and lower premiums
<i>r</i> plan has outpatient prescription drug coverage d I am enrolling in Part D
senrollment from a Medicare Advantage Plan ease explain reason for disenrollment
her reasons specified here:
R NEW POLICY AND ARE SURE THAT YOU WANT TO
ite ha, NE 68175
nt B
re

^{*}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.

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

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:
OO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE REC	CEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO
© 1	
Signature of Agent, Broker or Other Representative MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha	
	Plaza, Omaha, NE 68175
Applicant	Plaza, Omaha, NE 68175 Applicant B
Applicant Signature	Applicant B Signature

^{*}Signature not required for direct response sales.

MUTUAL OF OMAHA INSURANCE COMPANY

Dear	
Thank you for agreeing to meet with me onDate	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 advisors or attorneys.	e meeting, including family members, financial
You have the right to end the meeting at any time.	
You have the right to contact the Department of Insura 1-800-927-4357.	nce for information, or to file a complaint at
The following individuals will be coming to your home	:
Name	License #
Name	License #
Sincerely,	
Mutual of Omaha Insurance Company Representative	

Health Insurance Underwritten by Mutual of Omaha Insurance Company
Both at Mutual of Omaha Plaza, Omaha NE, 68175 Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company



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	Applicant B
Received from	Received from
this ,,	this day of , ,
an application for FormPol	licy an application for FormPolicy
and/or Ridersan	nd and/or Ridersand
Check forDollar	rs. Check forDollars.
🖾 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, 3300 MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.