California — Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code (Required only if you are not appointed or licensed or are changing brokerage firms)
Jorge Jiron		%	
		%	

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – Mutual of Omaha Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Household Premium Discount Information
- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question 7 OR BOTH questions 8 and 9 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section I: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section K: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Calculate Your Premium form**
- One month's premium is collected at the time of 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 with Notice of Information Practices**

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

Note: An interviewer may call to verify/confirm the information provided on the application. This form is required if splitting commissions.

MAP620_CA_0220

Mutual of Omaha

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 x .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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Agent Writing # _____ FAV Key _____ Auth # _____

Group # (if applicable) _____ Keyline _____

Mutual of Omaha Insurance Company

Application for Medicare Supplement Coverage

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

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): ☐ Plan A ☐ Plan G ☐ 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	**Plan (select one):** ☐ Plan A ☐ Plan G ☐ 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
Requested Effective Date ___ / ___ / ____	**Requested Effective Date** ___ / ___ / ____
Deliver Policy to Applicant A ☐ Producer ☐	Deliver Policy to Applicant B ☐ Producer ☐

B. Applicant Information (Must be completed in ink!)

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 ___ – ___ – ____ (area code)	Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ___ / ___ / ____ mo day yr	Current Age _____ Date of Birth ___ / ___ / ____ mo day yr

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B. Applicant Information (Continued - Must be completed in ink!)

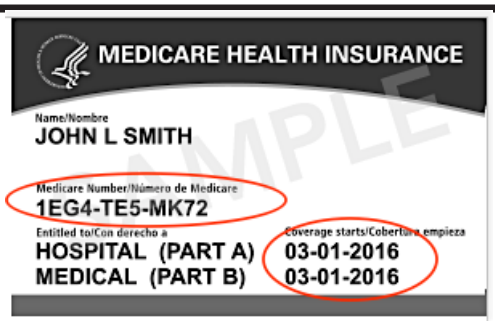
Applicant A	Applicant B
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ..... ☐ Y ☐ N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ..... ☐ Y ☐ 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 not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Mutual of Omaha.

Receive statement online? ..... ☐ Y ☐ N	Receive statement online? ..... ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date __/__/____ If you are not covered under Medicare Part A, what is your eligibility date __/__/____	Medicare Part A Effective Date __/__/____ If you are not covered under Medicare Part A, what is your eligibility date __/__/____
Medicare Part B Effective Date __/__/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll __/__/____	Medicare Part B Effective Date __/__/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll __/__/____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant B**
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?	☐ Y ☐ N	☐ Y ☐ 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:	Applicant A	Applicant B
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.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid or Medi-Cal pay your premiums for this Medicare supplement policy?	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid or Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐ 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?	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?	☐ Y ☐ N	☐ Y ☐ N

(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).....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank ..... Applicant A START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

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?	☐ Y ☐ N	☐ Y ☐ N

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

Applicant B ☐☐/☐☐/☐☐☐☐

(d) Was this your first time in this type of Medicare plan?	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Y ☐ N	☐ Y ☐ N
(f) Is your former Medicare supplement or Medicare Select policy/certificate still available?	☐ Y ☐ N	☐ Y ☐ N

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

Other: _____
Applicant A

_____
Applicant B

Please answer questions regarding other health insurance:

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

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

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

Applicant A START ___/___/_____
END ___/___/_____
Applicant B START ___/___/_____
END ___/___/_____

(b) Planned date of termination/disenrollment? ..... Applicant A ___/___/_____
Applicant B ___/___/_____

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

(d) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

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

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

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you applying during a guaranteed issue period? (NOTE: Refer to Section J of this application to help identify if you are eligible. Please attach proof of eligibility if in a guaranteed issue period.)	☐ Y ☐ N	☐ Y ☐ N
8. Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
9. Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If "YES," indicate your Medicare Part B effective date .....Applicant A ___/___/_____
Applicant B ___/___/_____

STOP

IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I. (NOTE: REFER TO SECTION J OF THIS APPLICATION TO HELP IDENTIFY IF YOU ARE ELIGIBLE)

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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 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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
12. Are you currently receiving any occupational, speech or physical therapy?	☐ Y ☐ N ☐ NS	☐ Y ☐ 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	☐ 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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
C. Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
E. Systemic Lupus, scleroderma or Myasthenia Gravis?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
H. Chronic hepatitis or cirrhosis?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
I. Osteoporosis with fractures?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ 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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ 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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ 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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
C. Alcoholism or drug abuse?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
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?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
18. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS
19. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N ☐ 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? **(If YES, please complete the Medication Information sheet on the next page)**	☐ Y ☐ N ☐ NS	☐ Y ☐ N ☐ NS

22. Applicant A (Height) Ft ☐ In ☐☐ (Weight) Lbs ☐☐☐ ☐ NS

Applicant B (Height) Ft ☐ In ☐☐ (Weight) Lbs ☐☐☐ ☐ NS

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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. 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

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	

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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 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.

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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)

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J. 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.*

J. 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.

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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)..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant(s)..... ☐ Y ☐ N

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 Date

Jorge Jiron
Printed Name

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

Jorge Jiron
Printed Name

Agent Writing Number

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ **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. I want my payments automatically withdrawn from my bank		
a. Choose the day payments will be deducted every month from your bank account.....	1st through the 28th or the last day of every month	1st through the 28th or the last day of every month
OR		
b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

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 inforce, 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
1. **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	☐	☐

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Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

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

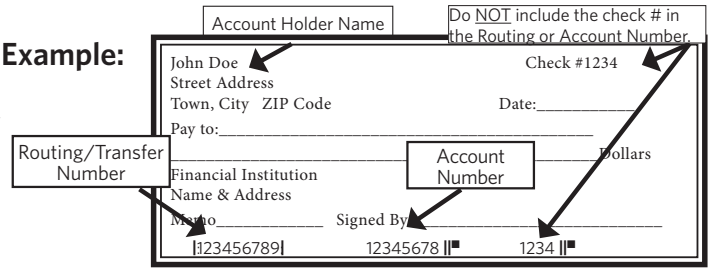
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

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

Example:



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

Applicant A

✍ _____
Authorized Signature as Shown on Account

_____
Date

Applicant B

✍ _____
Authorized Signature as Shown on Account

_____
Date

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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.

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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:
_____	_____
_____	_____
_____	_____

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.

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M18362_CA

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.

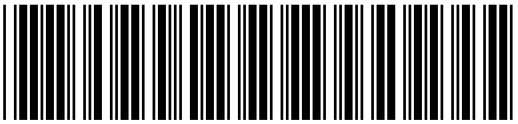
You have the right to contact the Department of Insurance for information, or to file a complaint at 1-800-927-4357.

The following individuals will be coming to your home:

Jorge Jiron
_____
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

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Mutual of Omaha

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.

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