

MUTUAL *of* OMAHA INSURANCE COMPANY

# APPLICATION for INDIVIDUAL DISABILITY INCOME

NEW JERSEY

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MUTUAL *of* OMAHA INSURANCE COMPANY  
Mutual of Omaha Plaza  
Omaha, NE 68175  
[mutualofomaha.com](http://mutualofomaha.com)

MAP38\_NJ

# INDIVIDUAL DISABILITY INCOME

## Application Submission Checklist

**Application**

- 1 Must be taken during an in-person interview.
- 2 Answer all questions completely.
- 3 Be sure to leave all applicable forms with the proposed insured.
- 4 Sign and Date in all places indicated.
- 5 See reverse side of this page for detailed information.

**Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

**Collect Premium Amount**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

**Attach Copy of Quote (if available)**

**Schedule Paramed Exam as Applicable**

APPS 1-800-635-1677

PORTAMEDIC 1-800-765-1010

**Initiate the Client Profile process with the Proposed Insured  
Call 1-800-775-3000**

**Indicate Underwriting Requirements Initiated or Completed**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Client Profile Interview | <input type="checkbox"/> MD Exam    |
| <input type="checkbox"/> Blood Profile            | <input type="checkbox"/> EKG        |
| <input type="checkbox"/> Physical Data            | <input type="checkbox"/> Mammogram  |
| <input type="checkbox"/> Long Form                | <input type="checkbox"/> Urinalysis |

**Indicate Financial Requirements Completed**

- Financials are generally not required if applying for Short-Term Accident Only coverage up to \$3,000.
- Individuals who have been self-employed less than 12 months must provide a Profit and Loss/Expense Statement.

**Any Additional Information or Comments**

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**NOTE: BROKERAGE ONLY – Please list your “commission code” in the box on the first page of the application. This will help avoid delay in commission payment.**

**DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION**

**There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.**

#### **Part 1: APPLICATION**

- Notify the applicant that a telephone interview will be conducted to obtain additional information and/or to verify application information.

#### **Section A: General Questions/Other Coverage Information/Income Information**

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.
- All details of other coverages (in force or being applied for) must be listed.
- Complete all income information in full and provide details in the area provided.

#### **Section B: Accident Only Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section C: Short-Term, Long-Term or Business Operating Expense Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section D: Business Operating Expense Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section E: Plan Information**

- Complete all details of plan selected and rider information.
- Check the Benefit Reduction Rider if applicant is eligible for any state guaranteed disability program.

#### **Section F: Premium Information**

- The total premium amount must be listed. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual BSP), and amount of initial and renewal premium.
- If PRD mode, complete the PRD Authorization form.

#### **Section G: BSP Authorization**

- Specify date premiums will be withdrawn.
- Attach check for the account from which premiums will be withdrawn.

#### **Section H: Agreements**

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

#### **Part 2: ADMINISTRATIVE FORMS**

##### **Appendix 1: Authorization to Disclose Personal Information**

- The HIPAA authorization is to be signed and returned with the application.

##### **Appendix 2: Authorization to Receive Information From and Disclose Information to the MIB Group**

- The MIB authorization is to be signed and returned with the application.

##### **Appendix 3 : Agent/Producer Statement**

- This is necessary information for the underwriting process.

##### **Appendix 4, 5 & 6: Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice**

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

##### **Receipt and/or Temporary Health and Accident Insurance Agreement**

- Detach and leave with proposed insured.

##### **State-Specific Forms – complete if applicable**

- Be sure to include all state appropriate forms.

##### **Replacement Notice – complete if applicable**

- Complete and leave a copy with applicant (if applicable).

##### **HIV Consent Form – complete if applicable**

- Form must be signed and dated. Detach 1st copy and leave with Proposed Insured.

##### **Drug, Alcohol Usage, Avocation Questionnaires – complete if applicable**

- Complete all information in full, sign and date.

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By



# Application For:

Mutual of Omaha Insurance Company  
 Mutual of Omaha Plaza  
 Omaha, NE 68175

- ACCIDENT ONLY DISABILITY INSURANCE
- SHORT-TERM DISABILITY INSURANCE
- LONG-TERM DISABILITY INSURANCE
- BUSINESS OPERATING EXPENSE DISABILITY INSURANCE

## SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

### PROPOSED INSURED INFORMATION

<p><b>1.</b> Proposed Insured's Name (First, Middle, Last) _____</p> <p><b>2.</b> Sex <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p><b>3.</b> Age _____ DOB ____/____/____</p> <p><b>4.</b> Birth State _____</p> <p><b>5.</b> Height (Ft &amp; In) _____ Weight (Lbs) _____</p> <p><b>6.</b> Home Tel. Number ( _____ ) _____        Daytime Tel. Number ( _____ ) _____        Best Time to Call _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p> <p><b>7.</b> Legal Residence Address (Number, Street, City, State, Zip) _____        _____</p> <p><b>8.</b> E-Mail Address (optional) _____</p> <p><b>9.</b> Mailing Address for Premium Notices (Number, Street, City, State, Zip) _____        _____</p> <p><b>10.</b> Full name of beneficiary _____        Relationship to Proposed Insured _____</p> <p><b>11.</b> Social Security Number _____ - _____ - _____</p> <p><b>12.</b> Drivers License Number _____</p> <p><b>13.</b> Are you a citizen of the United States?.....<input type="checkbox"/> Yes <input type="checkbox"/> No        If "No," please include your Permanent Resident Card form I-551 (also known as an "Alien registration Receipt Card" or "Green Card") number _____        and Visa Type _____</p>	<p>If not a citizen of the United States, have you resided in the United States at least 3 consecutive years?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>14.</b> Employer _____        Address _____        Business Phone Number _____        Occupation _____        List exact duties _____        _____</p> <p><b>15.</b> How long have you been employed in your current position?        _____ Years _____ Months</p> <p><b>16.</b> Proposed Insured's Employment Status:  <input type="checkbox"/> Employee (No Ownership)  <input type="checkbox"/> Sole Proprietor  <input type="checkbox"/> Partner in Partnership _____ % Ownership  <input type="checkbox"/> Shareholder in Sub "S" Corp. _____ % Ownership  <input type="checkbox"/> Owner of C – Corp. _____ % Ownership        Number of Full-time Employees _____        Do you have any part-time or off-season occupation?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," describe duties) _____        _____</p> <p><b>17.</b> Are you a member of an Association Group or Franchise?  <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," full name of organization _____        _____        Date joined (Mo./Yr.) _____ - _____</p>
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### OTHER COVERAGE AND REPLACEMENT INFORMATION

**1.** Are you covered under or eligible for the Federal Employee's Compensation Act (FERS or CSRS) or the Railroad Retirement Act?..... Yes  No

**2.** Are you covered under or eligible for any state government disability program?..... Yes  No

**3.** Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance? .... Yes  No  
 If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**4. Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.**  
 I am requesting termination of my Policy No. \_\_\_\_\_  
 on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

**INCOME INFORMATION**

<b>1. Income information</b> (Attach financial records if required. See underwriting guide for details)	Current Year	Prior Year
(a) Gross Annual Earned Income .....	\$ _____	\$ _____
(b) If self employed, net annual earned income from your occupation (after business expenses and before taxes).....	\$ _____	\$ _____
(c) Bonus, First Year Commissions and other incentive payments.....	\$ _____	\$ _____
(d) Other Earned Income (Part-time, off-season, etc.) .....	\$ _____	\$ _____
<b>Total</b> .....	<b>\$ _____</b>	<b>\$ _____</b>

**2. During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed \$1,500 per month? .....**  Yes  No

If "Yes," average over last 12 months..... \$ \_\_\_\_\_

**SECTION B Complete only if applying for Accident Only Disability Insurance**

<p><b>1.</b> During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit a Drug or Alcohol Use Questionnaire)</p> <p><b>2.</b> During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit an Avocation Questionnaire)</p>	<p><b>3.</b> During the last 3 years, have you had your drivers license suspended or revoked? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details _____</p> <p><b>4.</b> During the last 3 years, have you received or been advised by a healthcare provider (including chiropractor) to have treatment for any injury, impairment or disability? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give details below. (Attach a separate signed sheet if necessary.)</p>
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Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION C Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.**

**1. During the last 10 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 9.**

<input type="checkbox"/> Kidney or Urinary Tract <input type="checkbox"/> Cancer or Tumor <input type="checkbox"/> Heart or Coronary Arteries <input type="checkbox"/> Alcohol or Drug Abuse <input type="checkbox"/> Liver or Hepatitis <input type="checkbox"/> Stroke or Cerebral Vascular condition <input type="checkbox"/> Diabetes or Glandular condition <input type="checkbox"/> Psychological, Emotional or Psychiatric condition <input type="checkbox"/> Upper or Lower Digestive Tract <input type="checkbox"/> Spine, Neck or Back <input type="checkbox"/> High Blood Pressure, Arteries or Veins <input type="checkbox"/> Arthritis or Joints (including replacements)	<input type="checkbox"/> Anemia or Blood <input type="checkbox"/> Lung or Breathing Problem <input type="checkbox"/> Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy) <input type="checkbox"/> Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's) <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Skin or Connective Tissue <input type="checkbox"/> Fibromyalgia or Myalgia <input type="checkbox"/> Epstein-Barr Viral Infection <input type="checkbox"/> <b>None of These</b>
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**SECTION C**

**Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance. - continued**

2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? .....  Yes  No
3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)? .....  Yes  No  
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name (copy from pharmacy label, if applicable)
Dosage/Frequency
Date
Reason
Prescribing Physician (if applicable)
Phone Number (if applicable)

4. During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? .....  Yes  No
5. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? .....  Yes  No  
(If "Yes," submit a Drug or Alcohol Use Questionnaire)
6. Have you:  
(a) ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? .....  Yes  No  
If "Yes," provide details \_\_\_\_\_  
\_\_\_\_\_  
(b) ever applied for or received disability benefits of any kind? .....  Yes  No  
If "Yes," provide details \_\_\_\_\_  
\_\_\_\_\_
7. Are you pregnant? .....  Yes  No
8. Other than previously answered, during the last 10 years have you (a) been advised to have any medical test or surgical operation that was not performed, or (b) had any medical test or surgical operation performed, or (c) gone to a hospital, doctors' office (including chiropractic), clinic, dispensary or sanatorium for observation, examination or treatment? .....  Yes  No

9. Complete this section to expand on questions 1 and 8 in Section C. (Attach a separate signed sheet if necessary.)

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

**SECTION D**

**Complete only if applying for BUSINESS OPERATING EXPENSE Insurance**

1. Is your business conducted at your place of residence? .....  Yes  No  
If "Yes," what percent of your duties are performed outside of your place of residence? ..... \_\_\_\_\_ %
2. Date business established? ..... \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

**Average Monthly Expenses:**

<table style="width: 100%; border-collapse: collapse;"> <tr><td>No. of employees</td><td>_____</td></tr> <tr><td>Employees' salaries</td><td>\$ _____</td></tr> <tr><td>Interest on loans</td><td>\$ _____</td></tr> <tr><td>Mortgage interest payments</td><td>\$ _____</td></tr> <tr><td>Insurance (casualty/liability)</td><td>\$ _____</td></tr> <tr><td>Property taxes (real and personal)</td><td>\$ _____</td></tr> <tr><td>Depreciation (office equipment only)</td><td>\$ _____</td></tr> <tr><td>Rent (including land rental)</td><td>\$ _____</td></tr> <tr><td>Electricity</td><td>\$ _____</td></tr> <tr><td>Heat</td><td>\$ _____</td></tr> </table>	No. of employees	_____	Employees' salaries	\$ _____	Interest on loans	\$ _____	Mortgage interest payments	\$ _____	Insurance (casualty/liability)	\$ _____	Property taxes (real and personal)	\$ _____	Depreciation (office equipment only)	\$ _____	Rent (including land rental)	\$ _____	Electricity	\$ _____	Heat	\$ _____	<table style="width: 100%; border-collapse: collapse;"> <tr><td>Water</td><td>\$ _____</td></tr> <tr><td>Telephone</td><td>\$ _____</td></tr> <tr><td>Postage and stationery</td><td>\$ _____</td></tr> <tr><td>Equipment rental</td><td>\$ _____</td></tr> <tr><td>Laundry</td><td>\$ _____</td></tr> <tr><td>Other fixed operating expenses (please itemize)</td><td>_____</td></tr> <tr><td></td><td>\$ _____</td></tr> <tr><td></td><td>\$ _____</td></tr> <tr><td></td><td>\$ _____</td></tr> <tr><td><b>Total Monthly Expenses</b></td><td><b>\$ _____</b></td></tr> </table>	Water	\$ _____	Telephone	\$ _____	Postage and stationery	\$ _____	Equipment rental	\$ _____	Laundry	\$ _____	Other fixed operating expenses (please itemize)	_____		\$ _____		\$ _____		\$ _____	<b>Total Monthly Expenses</b>	<b>\$ _____</b>
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**SECTION E****PLAN INFORMATION****ACCIDENT ONLY DISABILITY INSURANCE****Monthly Benefit Amount \$** \_\_\_\_\_**Elimination Period:**  14 Days  30 Days  60 Days  90 Days**Benefit Period:**  6 Months  12 Months  24 Months**Optional Riders:** Benefit Reduction Rider (Check only if eligible for any state guaranteed disability program) Hospital Confinement Accident Indemnity Benefits Rider  \$125  \$250**SHORT-TERM DISABILITY INSURANCE****Monthly Benefit Amount \$** \_\_\_\_\_**Elimination Period Accident/Sickness:**  14 Days  30 Days  60 Days  90 Days**Benefit Period:**  6 Months  12 Months  24 Months**Optional Riders:** Benefit Reduction Rider (Check only if eligible for any state guaranteed disability program) Hospital Confinement Indemnity Benefits Rider  \$125  \$250**LONG-TERM DISABILITY INSURANCE****Base Monthly Benefit Amount \$** \_\_\_\_\_ **SIS Monthly Benefit Amount \$** \_\_\_\_\_**Elimination Period:**  60 Days  90 Days  180 Days  365 Days (Not available with 2- year benefit period)**Benefit Period:**  2 Years  5 Years  10 Years  To Age 67**Optional Riders:** Benefit Reduction Rider (Check only if eligible for any state guaranteed disability program) SIS (Social Insurance Substitute) Benefits Rider  
Do you have any dependent children age 17 or under?  Yes  No  
Are you covered under the Social Security Act?  Yes  No Cost-of-Living Adjustment (COLA) Rider Hospital Confinement Indemnity Benefits Rider  
(Check one option)  \$125  \$250 Extended Proportionate Disability Benefits Rider Future Insurability Option (FIO) Rider Extended Own-Occ. Disability Defin. Amend. Rider**BUSINESS OPERATING EXPENSE DISABILITY INSURANCE****Monthly Benefit Amount \$** \_\_\_\_\_**Elimination Period:**  30 Days  60 Days  90 Days  180 Days  365 Days**Benefit Period:**  12 Months  18 Months

**SECTION F****PREMIUM COLLECTION**

Amount Collected \$ \_\_\_\_\_ Initial Premium \$ \_\_\_\_\_ Renewal Premium \$ \_\_\_\_\_

**Billing Mode:**     Monthly     Quarterly     Semiannual     Annual Bank Service Plan (BSP) - Complete 'Authorization to Withdraw Funds' (If BSP is selected, collect 2 months of premium.) Payroll Deduction

Add to Existing PRD – Group Number..... \_\_\_\_\_

First Deduction Date ..... \_\_\_\_\_

Number of Deductions..... \_\_\_\_\_

Effective Date of Payroll Deduction ..... \_\_\_\_\_

**SECTION G****Complete only if Billing Mode is BSP****AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")**

As a convenience to me, I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn:     1st of the Month    or     15th of the Month
2. Attach your check from the account from which premiums will be withdrawn.

**SECTION H****PLEASE READ AND SIGN****AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. ("MIB")**

– **The MIB Group, Inc. ("MIB")** is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to Mutual of Omaha Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize Mutual of Omaha Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

**AGREEMENT** – I, the undersigned, agree that (a) all statements and answers in this application are true and complete to the best of my knowledge and belief. (b) Mutual

of Omaha Insurance Company will rely upon these answers to determine insurability, and (c) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the date of the policy will be the date of the application or the expiration of any replaced coverage, if later.

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, I must complete all required examinations and tests (medical, paramedical, laboratory), and Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests and any other information (such as an Attending Physician's Statement) that is requested by Mutual of Omaha Insurance Company to underwrite the application. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date. **If I am not eligible for the insurance applied for or any substitute policy, I agree that no policy of any kind will be in effect except for coverage provided by any Temporary Health and Accident Insurance Agreement.**

In no event will any benefits be paid for the same loss under both any Temporary Insurance Agreement and any policy issued from this application.

No Agent/Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

**SECTION H**

**PLEASE READ AND SIGN - continued**

**FRAUD WARNING** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee Residents Only:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Notice to Colorado Residents Only:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Notice to District of Columbia/Pennsylvania Residents Only:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Florida Residents Only:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Notice to Kansas Residents Only:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact

material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

**Notice to New Jersey Residents Only:** Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

**Notice to Oregon Residents Only:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be crime and may subject such person to criminal and civil penalties.

**Notice to Puerto Rico Residents Only:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

**Notice to Tennessee Residents Only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Notice to Vermont Residents Only:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Notice to Virginia Residents Only:** Must include “may have violated state law” in the fraud statement. Therefore, use this fraud warning statement: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**I have (a) read and understand the Agreement and Fraud Warning Section and any Receipt provided; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.**

Signature of Proposed Insured \_\_\_\_\_ Printed Name of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_

Signature of Payor as shown on bank account \_\_\_\_\_ Printed Name of Payor \_\_\_\_\_ Date \_\_\_\_\_  
(if Billing Mode is BSP and Payor is other than Proposed Insured)

**I/We certify that during an in-person interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ....**  Yes  No

(If "No," please explain.) \_\_\_\_\_

Signature of Producer \_\_\_\_\_ Producer's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Office Name \_\_\_\_\_ Office Address \_\_\_\_\_

Signature of Producer \_\_\_\_\_ Producer's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Office Name \_\_\_\_\_ Office Address \_\_\_\_\_

**Meanings of Terms**

**“Medical Persons and Entities” means:** all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Disclose**

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

**Purposes**

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

**Potential for Redisclosure**

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

**Failure to Sign**

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

**Expiration and Revocation**

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting  
Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that 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.

**Copy**

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

**Names and Signatures**

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

Printed Name of Proposed Insured \_\_\_\_\_ Spouse’s Printed Name \_\_\_\_\_ If children are to be insured, their printed names \_\_\_\_\_  
(If Proposed Insured)

Signature of Proposed Insured \_\_\_\_\_ Signature of Spouse \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_  
(If Proposed Insured)

Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

**Meanings of Terms**

**“MIB Group, Inc. (MIB)” means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**“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 and, if my children are proposed insureds, my children also.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

- 1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.).....  Yes  No
- 2 Has a medical examination of the Proposed Insured been scheduled?.....  Yes  No  
If "Yes," when? \_\_\_\_\_ By \_\_\_\_\_
- 3 Has the client profile interview been completed? .....  Yes  No  
If "No," the client profile interview has been scheduled for \_\_\_\_\_ and \_\_\_\_\_  
Date Time (Please circle -Eastern, Central, Mountain or Pacific)
- 4 Did you give the Notice of Information Practices to the Proposed Insured?.....  Yes  No  
Date \_\_\_\_\_  
Mo. Day Yr. \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_

**Agent/Producer Information:**

Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____
Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____

**Appendix 4****Mutual of Omaha Insurance Company  
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. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

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

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

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

**Appendix 5****Mutual of Omaha Insurance Company  
MIB Group, Inc. Pre-Notice**

The information regarding your insurability will be treated as confidential.

However, the Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply for life and health insurance to another company which is also a member of MIB or if a claim for benefits is submitted to such a company, MIB will, upon request, supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is P.O. Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.

In compliance with applicable law, the Company or its reinsurers may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

**Appendix 6****Mutual of Omaha Insurance Company  
Investigative Consumer Reports Notice**

Mutual of Omaha Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

**All checks for premiums must be made payable to Mutual of Omaha Insurance Company. Do not make checks payable to the producer or leave the payee blank.**

## Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for \_\_\_\_\_

In consideration of the application and payment of \$ \_\_\_\_\_ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
  - (a) The date the above sum is received; or
  - (b) The date the application is signed; or
  - (c) The date this Agreement is signed by both parties.
2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
  - (a) 90 days from the date of this Agreement; or
  - (b) The date that insurance takes effect under the policy/certificate applied for; or
  - (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
  - (d) The date the premium refund is mailed; or
  - (e) The date Mutual mails notice of termination of coverage.
3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**
4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**
6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_  
(Month) (Year) City State ZIP Code

\_\_\_\_\_  
Agent/Producer's Signature

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Please Print Name

All checks for premiums must be made payable to Mutual of Omaha Insurance Company. Do not make checks payable to the producer or leave the payee blank.

# Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for \_\_\_\_\_

In consideration of the application and payment of \$ \_\_\_\_\_ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
  - (a) The date the above sum is received; or
  - (b) The date the application is signed; or
  - (c) The date this Agreement is signed by both parties.
2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
  - (a) 90 days from the date of this Agreement; or
  - (b) The date that insurance takes effect under the policy/certificate applied for; or
  - (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
  - (d) The date the premium refund is mailed; or
  - (e) The date Mutual mails notice of termination of coverage.
3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**
4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**
6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_  
(Month) (Year) City State ZIP Code

\_\_\_\_\_  
Agent/Producer's Signature Signature of Proposed Insured Please Print Name

# Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175

---

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on \_\_\_\_\_.  
Date

\_\_\_\_\_  
Applicant's Signature

# Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175

---

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on \_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

# Drug Usage Questionnaire

Mutual of Omaha Insurance Company  
 Mutual of Omaha Plaza  
 Omaha, NE 68175  
 Attn: Individual Health Underwriting

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

- 2A. Are you now using or have you used during the last 10 years any of the following drugs:
- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| (a) Opium derivatives: Heroin, Morphine, Demerol, Methadone, Codeine, Percodan, Dilaudid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Marijuana: Hashish, Cannabis.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Amphetamines: Benzedrine, Dexedrine, Methedrine, Preludin.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Cocaine, Crack.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Hallucinogens: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Sedatives and Tranquilizers: Librium, Valium, Quaalude, Dalmane, Placidyl.....            | <input type="checkbox"/> | <input type="checkbox"/> |

2B. Were any of the above prescribed by a physician?  Yes  No If "Yes," which? \_\_\_\_\_

3. If "Yes" answers in 2A or 2B, please give details.

Type	Usual Quantity	Frequency of Use	How Taken (Oral, Injection, Inhaled, Smoked, Etc.)	Date: From — To

4. Except those prescribed by a physician, are you now using or have you used during the last 10 years any other drugs not listed in number 2 or 3 above?  Yes  No If "Yes," explain. \_\_\_\_\_

5. Have you ever sought medical treatment because of drug usage? .....  Yes  No  
 If "Yes," state dates and names of doctors and institutions consulted. \_\_\_\_\_

6. Please indicate any additional relevant information. \_\_\_\_\_

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Signature of Proposed Insured

# Alcohol Use Questionnaire

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
Attn: Individual Health Underwriting

---

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

1. Do you presently use alcoholic beverages?  Yes  No If "No," date of last drink. \_\_\_\_\_

If "Yes," please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. Did you ever drink substantially more than at present?  Yes  No If "Yes," during what time period?

Dates: From \_\_\_\_\_ To \_\_\_\_\_

Please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Why did you change your drinking habits? \_\_\_\_\_

3. Are you active in Alcoholics Anonymous or other recovery groups?  Yes  No How long? \_\_\_\_\_

4. Have you ever consulted a doctor or received treatment because of your alcohol use?  Yes  No

If "Yes," indicate name and address of any doctor, hospital or treatment center and dates of treatment. \_\_\_\_\_

5. Are you presently taking, or have you ever taken, Antabuse or any other medication to control your drinking?

Yes  No If "Yes," please indicate date last used and name of doctor who prescribed it. \_\_\_\_\_

6. Have you ever been arrested for driving under the influence of alcohol?  Yes  No If "Yes," give dates and driver's license number. \_\_\_\_\_

7. Have you ever used any other drugs, except over-the-counter drugs or those prescribed by a physician?

Yes  No (If answered "Yes," please complete Drug Usage Questionnaire.)

8. Remarks \_\_\_\_\_

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Proposed Insured

# Avocation Questionnaire

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
Attn: Individual Health Underwriting

---

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

## 1. Type of Avocation:

- Motorcycle Racing
- Auto Racing
- Boat Racing
- Stunt Driving
- Aircraft Piloting
- Rodeo Activities
- Rock/Mountain Climbing
- Sky Diving
- Scuba Diving
- Other \_\_\_\_\_

2. How many times per year do you participate in this activity? \_\_\_\_\_

3. Do you plan to continue participating in this activity in the future?  Yes  No

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Proposed Insured

# Foreign National and Foreign Travel Questionnaire



## To be completed by Proposed Insured(s) or Policyowner(s)

1 Are you a U.S. citizen?.....  Yes  No  
**(If "Yes," proceed to Question 2.)**

(a) Are you a Permanent Resident (holder of a Permanent Resident Card)?.....  Yes  No

(1) If "Yes," please list your Permanent Resident Card Number: \_\_\_\_\_

(2) If "No," please list the type of visa you hold: \_\_\_\_\_ How long have you lived in the United States? \_\_\_\_\_

(b) Please provide your full name as stated on the Permanent Resident Card or Visa: \_\_\_\_\_

(c) Date of issue on your Permanent Resident Card or Visa: \_\_\_\_\_

(d) Date of expiration on your Permanent Resident Card: \_\_\_\_\_

(e) Country of Birth: \_\_\_\_\_

(f) Do you own a home in the United States?.....  Yes  No

If "Yes," please provide the address: \_\_\_\_\_

(g) Do you own a home in a foreign country? .....  Yes  No

If "Yes," please provide the address: \_\_\_\_\_

(h) If married, does your family live with you in the United States?.....  Yes  No

2 Are you employed in the United States? .....  Yes  No

(a) If "Yes," please provide the name and address of your employer and describe the duties you perform. \_\_\_\_\_

(b) If "No," please provide source(s) of income while living in the United States. \_\_\_\_\_

3 Do you plan to travel outside of the United States in the next two years? .....  Yes  No

**(If "Yes," please answer the following questions below:)**

(a) Where do you plan to travel? \_\_\_\_\_

(b) What is the purpose of travel?  Business  Pleasure

(c) How often? \_\_\_\_\_

(d) Average period of time for each trip: \_\_\_\_\_

(e) What was the date of your last trip? \_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Signature(s) of Proposed Insured(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature(s) of Policyowner(s)

\_\_\_\_\_  
Date

**Producer Statement:** In the presence of the insured(s) I have asked each question as written and have recorded the answers completely and accurately. If question 1 was answered "No," I have seen the proposed insured(s) or policyowner(s) Permanent Resident Card.....  Yes  No

If "No," please provide explanation. \_\_\_\_\_

\_\_\_\_\_  
Signature(s) of Producer(s)

\_\_\_\_\_  
Date

# Guidelines When Considering Immigrants and Non-Immigrants for Insurance Coverage



**Acceptable Immigrant Status For Consideration of Life and/or Health Insurance Coverage.** An individual with a valid Alien Registration Receipt Card (also known in layman's term as a "Green Card") will be eligible to apply for such coverage. In addition, the individual must meet all four requirements listed below:

1. Reside in the United States for a minimum of 12 consecutive months to apply for life insurance coverage and 36 consecutive months to apply for health insurance coverage.
2. Have a minimum net annual income of \$20,000 from U.S. based assets or entitlement benefits (i.e., social security or pension benefits) or U.S. based employment.
3. Show intent to reside permanently in the United States. Some examples of this intent are:
  - Own a home in the United States,
  - Own business in the United States, and/or,
  - Have child or children who are United States citizens and who reside in the United States.
4. Complete the Foreign Travel Questionnaire (L5719\_1103).

**Unacceptable Non-Immigrant Visas.** Except as otherwise noted below, individuals who have the following temporary visas WILL NOT be considered for life and/or health insurance coverage:

A-1	D-2	H-1C	L-2*	P-4
A-2	E1	H-2A	M-1	Q-1
A-3	E2	H-2B*	M-2	Q-3
B-1	F1	H-3	N-8	R-1
B-2	F2	H-4	N-9	R-2
C-1	G1	J-1	O-1	S-5
C-1D	G2	J-2	O-2	S-6
C-2	G3	K-1	O-3	
C-3	G4	K-2	P-1	
C-4	G5	L-1A*	P-2	
D-1	H-1B*	L-1B*	P-3	

We will also not consider individuals who reside in the United State because of their receipt of a Political Asylum or Humanitarian Asylum Visa.

**Note:** Some individuals who have a valid H-1B, H-2B, L-1A, L-1B, or L-2 visa may be considered for life and/or health insurance coverage. The producer must contact Life Underwriting and/or Health Underwriting, as applicable, to discuss the case and obtain the applicable underwriting approval before completing an application.

**Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")**

**Meanings of Terms**

**"MIB Group, Inc. (MIB)" means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**"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 and, if my children are proposed insureds, my children also.

**"Specified Companies" means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

# BUSINESS OPERATING EXPENSE

## SUMMARY OF COVERAGE

### *For Policy Form 150BE*

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This coverage provides benefits for the operating expense of a business or a practice when the owner/Insured is completely unable to engage in his or her occupation (in CT, IA & VA, unable to engage in substantial and material duties of his or her occupation) as a result of covered illness or injury, receives no earnings for performing other work or service and receives medical treatment. Benefits of your plan are as indicated in your policy.

#### **Renewal Agreement**

We will renew your policy each time you send us the premium until you reach age 65. However, the policy will terminate when you retire, sell your business, or discontinue your business or the practice of your business or profession.

#### **Premium Change**

Your premium cannot be changed unless we make the same change on all policies of this form (and series in AL) issued to persons of the same classification in your state. In SC, you will receive at least 31 days' notice of a premium change.

#### **Accidental Death Benefit** (Not available in SC)

An amount equal to the total annualized premium of the policy and all riders in effect on the date of a covered accident, multiplied by the number of full years the policy has been in force, will be paid when such injury results in the Insured's death within 90 days (180 days in UT) after the date of the accident. This benefit is paid in addition to any other benefit under the policy. If there is a change of Insured, the Policy Date for this provision will be the date such change takes effect (not applicable in TN). (In TN, the minimum benefit is \$1,000).

In VA, benefit is payable if injuries you receive while the policy is in force cause your death within: (a) 90 days of the accident or (b) 12 months of the accident if, as a result of the accident, you suffered continuous total disability that began within 30 days of the accident. The benefit is an amount equal to the total annualized premium of the policy and all riders in effect on the date of the accident, multiplied by the number of full years the policy has been in force. It is payable in addition to any other benefit. The minimum benefit is \$1,000.00. If there is a change of Insured, the Policy Date, for this provision will be the date such change takes effect. Benefits are not payable for loss caused by suicide while sane or insane, an act of declared or undeclared war or sustained while in an armed service.

#### **Tax Deductible**

Your Business Operating Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings

which allow certain business professionals who are sole proprietors, partners and stockholders/employees of a business to use premiums for the policy as direct business expense for tax deduction. This is based on current tax code.

#### **Preexisting Sickness or Injury** (Not applicable in PA)

Means a sickness or injury which first makes itself known or is medically treated before the Policy Date and which must be disclosed as requested on the application. In MA, a sickness or injury makes itself known when the symptoms are clear enough to cause a prudent person to seek medical attention. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months. In AR, a sickness or injury for which medical advice or treatment was recommended by or received from a physician within five years from the Policy Date and which must be disclosed as requested on the application. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months.

In CT, IA & WA, benefits will not be payable for loss caused by any condition, which makes itself known during the five-year period prior to the date the person suffering the loss became insured. A condition will be considered to have made itself known when medical care or treatment has been given, or there exist symptoms which could cause an ordinarily prudent person to seek diagnosis, care or treatment. In CT, this provision does not affect our rights with respect to any material misrepresentations contained in the application.

In VA, Subject to the Time Limit on Certain Defenses provision, benefits are not payable under the policy for loss caused by any condition which makes itself known during the two-year period prior to the Policy Date. A condition will be considered to have made itself known when: (1) medical advice or treatment has been received from a physician; or (2) there exist symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

#### **Exceptions**

Benefits are not payable for: (a) loss beginning while the policy is not in force; (b) loss resulting from suicide while sane or insane (in MO, while sane only); (c) loss resulting from air

travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; (d) loss caused by an act of declared or undeclared war; (e) loss sustained while in an armed service (upon notice to the Company of entry into such service, the pro rata premium will be refunded); (f) normal childbirth, normal pregnancy or voluntarily induced abortion; or in MN childbirth or pregnancy; (g) in AR, loss resulting from certain pregnancy related conditions; (h) in KS, NH, PR and WA, childbirth, pregnancy or complications resulting therefrom; (l) in MN, alcoholism, drug addition or drug dependence.

In CO, FL, ID, MN, NC & UT, benefits are payable for complications of pregnancy on the same basis as any other covered sickness.

In MT & UT, subject to all policy provisions and limitations, maternity is payable on the same basis as any other sickness.

We will not be liable for any loss that results from being under the influence of any narcotic unless administered on the advice of a physician (not applicable in NM and VT).

### **Monthly Operating Expense Benefits**

When injuries or sickness results in total loss of time, we will pay benefits for operating expenses you incur during such total loss of time. Benefits are subject to the deductible (or elimination) period. Benefits for operating expenses incurred each month will be paid up to the average monthly (in PA, the maximum) operating expenses for the 12-month period immediately before the start of the total loss of time. Benefits are limited to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense Benefit for one accident or sickness.

In MA, PA, SC & VA, if benefits are payable for less than one month, the benefit payable for each day will be 1/30<sup>th</sup> of the average monthly operating expense as determined above. In TN, a pro rata benefit will be paid for a loss of less than one month.

A pro rata benefit will be paid for a loss of less than one month (TN only).

In the event that your average monthly operating expense decreases, the monthly benefits of your policy will be continued during a period of total loss of time until the Maximum Operating Expense Benefit is paid (not applicable in PA).

In NC, upon your written request, the Maximum Monthly Benefit may be increased. The increase will be effective on the first day of the calendar month following the date we receive your request and evidence of insurability. This adjustment cannot exceed the amount nearest your monthly office operating expense reported. A corresponding premium adjustment will also be made.

### **Operating Expenses**

Operating Expenses include: rent; electricity, heat, water and other utilities; telephone; laundry; accountant's service; salaries of employees; taxes; depreciation on office equipment; deterioration of supplies; payments of interest on business debts but not principal; postage and stationery; monthly prorate of annual charitable contributions; telephone answering service; prorate of business insurance premiums; membership fees and dues for professional and business societies or associations; subscription charges for business or professional periodicals; maintenance service and such other fixed expenses as are normal and customary in the conduct and operation of your office or business. In the event of joint occupancy or partnership, only your portion of such expenses is covered.

Operating expenses do not include: your salary; fees; drawing accounts or any other compensation received by you nor the cost of goods; wares; pharmaceutical products or professional books; equipment or other items not specifically named in your policy.

### **Other Features of Your Plan**

#### **Conversion Privilege**

Regardless of changes in your health, upon your written request for conversion of the policy, the Company agrees to issue an individual loss of time policy to replace this coverage. Written request must be submitted prior to the Insured's 60th birthday, and the Insured must then be regularly and gainfully employed on a full-time basis.

#### **Waiver of Premium**

The Company will waive premiums on the policy after total loss of time benefits have been paid continuously for three months. This waiver applies only to those premiums becoming due after such three-month period.

#### **Contains a Recurrent Provision**

In the event of further total loss of time as a result of sickness or injuries for which benefits have been payable, the Maximum Operating Expense Benefit and Deductible Period will be restored after the Insured returns to work on a full-time basis for a period of six consecutive months.

#### **Grace Period**

A grace period of 31 days will be granted for the payment of renewal premiums.

This is a brief description of some of the important features and benefits of this Business Operating Expense Policy. Additional information may be found in the brochure.

However, the policy itself details the rights and obligations of both you and Mutual of Omaha Insurance Company. PLEASE READ YOUR POLICY CAREFULLY.

Policy Form 150BE (in ID, Form 150BE Series-10116; in OK, Form 150BE Series-8972; in OR, Form 150BE Series-13316; in PA, Form 150BE Series-10501; in TX, Form 150BE Series-9068) or state equivalent.

Underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175, 402 342 7600

# ACCIDENT-ONLY SHORT-TERM DISABILITY INCOME PROTECTION COVERAGE – OUTLINE OF COVERAGE

**THIS POLICY COVERS ACCIDENTS ONLY**

**IT DOES NOT PAY BENEFITS FOR LOSS RESULTING FROM SICKNESS**

*For Policy Form D83-21078 and D83-21079*

## ACCIDENT DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident ONLY, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

### READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY! REMEMBER, if you are not satisfied with your policy, you have 10 days to return it to us and get your money back.

Annual Premium	\$ _____
You Pay	\$ _____ per _____

## TOTAL DISABILITY BENEFITS

If you are Totally Disabled because of an injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

## PARTIAL DISABILITY BENEFITS

If you are Partially Disabled because of an Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

## PRESUMPTIVE TOTAL DISABILITY BENEFITS

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if an Injury results in the complete and irrecoverable loss of your:

- (a) speech;
- (b) hearing in both ears;
- (c) sight in both eyes; or
- (d) the use of both hands, both feet or one hand and one foot.

## SURVIVOR BENEFIT

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

## **EXCLUSIONS**

We will not pay benefits for:

- (a) loss that begins while this policy is not in force;
- (b) loss resulting from an act of declared or undeclared war;
- (c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);
- (d) loss caused by intentionally self-inflicted injury (while sane in Colorado);
- (e) loss resulting from commission or attempted commission of a felony;
- (f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);
- (g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician);
- (h) loss resulting directly or indirectly from disease or bodily infirmity; or
- (i) loss for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law.

## **PREMIUMS WILL NOT INCREASE IF ASSOCIATION GROUP MEMBERSHIP OR SELF-EMPLOYMENT ENDS (Policy Form D83-21079 Only)**

This policy form was issued to you because you are a member of a franchise or association group and the organization sponsors this plan of insurance or you are self-employed. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change.

## **GUARANTEED RENEWABLE TO AGE 67**

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

## **PREMIUM CHANGES**

Your policy's premium may change, but only if the same change is made to all policies of this form issued to persons of the same Class. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, YOU MAY CALL US TOLL-FREE AT:

For Customer Service 1-800-775-6000  
For Claims Service 1-800-775-1000

# SHORT-TERM DISABILITY INCOME PROTECTION COVERAGE – OUTLINE OF COVERAGE

*For Policy Form D82-21076 and D82-21077*

## DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

## READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY! REMEMBER, if you are not satisfied with your policy, you have 10 days to return it to us and get your money back.

Annual Premium	\$ _____
You Pay	\$ _____ per _____

## TOTAL DISABILITY BENEFITS

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

## PARTIAL DISABILITY BENEFITS

If you are partially disabled because of a Sickness or Injury, we will pay 50% of the Total Disability Monthly Benefit. Partial Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Partially Disabled for the lesser of six months or the balance of the Benefit Period.

## PRESUMPTIVE TOTAL DISABILITY BENEFITS

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

- (a) speech;
- (b) hearing in both ears;
- (c) sight in both eyes; or
- (d) the use of both hands, both feet or one hand and one foot.

## TRANSPLANT DONOR BENEFITS

If you become Totally Disabled or Partially Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits on the same basis as any other Sickness.

## TERMINAL ILLNESS BENEFIT

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy.

## SURVIVOR BENEFIT

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

## REHABILITATION BENEFIT

While you are receiving Total Disability or Partial Disability benefits, we may pay for a vocational rehabilitation program.

## EXCLUSIONS AND LIMITATIONS

We will not pay benefits for:

- (a) loss that begins while this policy is not in force;
- (b) loss resulting from an act of declared or undeclared war;
- (c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);
- (d) loss caused by intentionally self-inflicted injury (while sane in Colorado);
- (e) loss resulting from commission or attempted commission of a felony;
- (f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);
- (g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician);
- (h) loss for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law;
- (i) loss resulting from substance abuse; or
- (j) loss resulting from mental or nervous disorders.

## PREGNANCY

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

## PREMIUMS WILL NOT INCREASE IF ASSOCIATION GROUP MEMBERSHIP OR SELF-EMPLOYMENT ENDS

(Policy Form D82-21077 Only)

This policy form was issued to you because you are a member of a franchise or association group and the organization sponsors this plan of insurance or you are self-employed. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change.

## GUARANTEED RENEWABLE TO AGE 67, CONDITIONALLY RENEWABLE THEREAFTER TO AGE 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

## PREMIUM CHANGES

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, YOU MAY CALL US TOLL-FREE AT:

For Customer Service 1-800-775-6000

For Claims Service 1-800-775-1000

# LONG-TERM DISABILITY INCOME PROTECTION COVERAGE – OUTLINE OF COVERAGE

*For Policy Form D81-21074 and D81-21075*

## DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

## READ YOUR POLICY CAREFULLY

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY! REMEMBER, if you are not satisfied with your policy, you have 10 days to return it to us and get your money back.

Annual Premium	\$ _____
You Pay	\$ _____ per _____

## TOTAL DISABILITY BENEFITS

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the Benefit Period.

## PROPORTIONATE DISABILITY BENEFITS

If you are Proportionately Disabled because of Sickness or Injury and incur a 20% or greater Loss of Monthly Income, we will pay a percentage of your Total Disability Monthly Benefit that is proportionate to your lost income.

## PRESUMPTIVE TOTAL DISABILITY BENEFITS

We will automatically pay Total Disability Benefits under your policy and any Social Insurance Supplement Benefits Rider for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

- (a) speech;
- (b) hearing in both ears;
- (c) sight in both eyes; or
- (d) the use of both hands, both feet or one hand and one foot.

## TRANSPLANT DONOR BENEFITS

If you become Totally Disabled or Proportionately Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits under your policy and any Social Insurance Supplement Benefits Rider on the same basis as any other Sickness.

## TERMINAL ILLNESS BENEFIT

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy and any Social Insurance Supplement Benefits Rider.

## SURVIVOR BENEFIT

Upon your death, we will pay a Survivor Benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

## REHABILITATION BENEFIT

While you are receiving Total Disability or Proportionate Disability benefits, we may pay for a vocational rehabilitation program.

## EXCLUSIONS AND LIMITATIONS

Benefits are not payable for:

- (a) loss that begins while this policy is not in force;
- (b) loss resulting from an act of declared or undeclared war;
- (c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);
- (d) loss caused by intentionally self-inflicted injury (while sane in Colorado);
- (e) loss resulting from commission or attempted commission of a felony;
- (f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri); or
- (g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician).

## PREGNANCY

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

## SUBSTANCE ABUSE LIMITATION

Benefits payable for Substance Abuse are limited to a lifetime maximum of 24 months.

## MENTAL OR NERVOUS DISORDER LIMITATION

Benefits payable for Mental or Nervous Disorders are limited to a lifetime maximum of 24 months.

## PREMIUMS WILL NOT INCREASE IF ASSOCIATION GROUP MEMBERSHIP OR SELF-EMPLOYMENT ENDS

(Policy Form D81-21075 Only)

This policy form was issued to you because you are a member of a franchise or association group and the organization sponsors this plan of insurance or you are self-employed. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change.

## GUARANTEED RENEWABLE TO AGE 67, CONDITIONALLY RENEWABLE THEREAFTER TO AGE 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

## PREMIUM CHANGES

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form issued to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, YOU MAY CALL US TOLL-FREE AT:

For Customer Service 1-800-775-6000

For Claims Service 1-800-775-1000