

MUTUAL *of* OMAHA INSURANCE COMPANY

APPLICATION for INDIVIDUAL DISABILITY INCOME

NEW YORK

MUTUAL *of* OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

MAP426_NY

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

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.

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>1. Proposed Insured's Name (First, Middle, Last) _____</p> <p>2. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>3. Age _____ DOB ____/____/____</p> <p>4. Birth State _____</p> <p>5. Height (Ft & In) _____ Weight (Lbs) _____</p> <p>6. Home Tel. Number (_____) _____ Daytime Tel. Number (_____) _____ Best Time to Call _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p> <p>7. Legal Residence Address (Number, Street, City, State, Zip) _____</p> <p>8. E-Mail Address (optional) _____</p> <p>9. Mailing Address for Premium Notices (Number, Street, City, State, Zip) _____</p> <p>10. Full name of beneficiary _____ Relationship to Proposed Insured _____</p> <p>11. Social Security Number _____ - _____ - _____</p> <p>12. Drivers License Number _____</p> <p>13. 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>14. Employer _____ Address _____ Business Phone Number _____ Occupation _____ List exact duties _____</p> <p>15. How long have you been employed in your current position? _____ Years _____ Months</p> <p>16. 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>17. 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 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

3. 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

1. Income information (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.)	\$ _____	\$ _____
Total	\$ _____	\$ _____

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>1. 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>2. 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>3. 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>4. 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. To the best of your knowledge and belief 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"/> None of These
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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) 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. To the best of your knowledge and belief 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. To the best of your knowledge and belief 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:

No. of employees	_____	Water	\$ _____
Employees' salaries	\$ _____	Telephone	\$ _____
Interest on loans	\$ _____	Postage and stationery	\$ _____
Mortgage interest payments	\$ _____	Equipment rental	\$ _____
Insurance (casualty/liability)	\$ _____	Laundry	\$ _____
Property taxes (real and personal)	\$ _____	Other fixed operating expenses (please itemize)	_____
Depreciation (office equipment only)	\$ _____		\$ _____
Rent (including land rental)	\$ _____		\$ _____
Electricity	\$ _____		
Heat	\$ _____	Total Monthly Expenses	\$ _____

SECTION E PLAN INFORMATION

ACCIDENT ONLY DISABILITY INSURANCE

Monthly Benefit Amount \$ _____

Elimination Period: 14 Days 30 Days 60 Days 90 Days

Benefit Period: 3 Months 6 Months 12 Months 24 Months

Optional Riders:
 Hospital Confinement Accident Indemnity Benefits Rider \$125 \$250 \$350 \$500

SHORT-TERM DISABILITY INSURANCE

Monthly Benefit Amount \$ _____

Elimination Period Accident/Sickness: 14 Days 30 Days 60 Days 90 Days

Benefit Period: 3 Months 6 Months 12 Months 24 Months

Optional Riders:
 Hospital Confinement Indemnity Benefits Rider \$125 \$250 \$350 \$500
 Specified Disease Benefits Rider (check one option) \$5,000 \$10,000 \$15,000 \$25,000

If applying for Specified Disease Benefits Rider, complete additional health question below:
 Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. Yes No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

LONG-TERM DISABILITY INSURANCE

Base Monthly Benefit Amount \$ _____ **SIS Monthly Benefit Amount \$** _____

Elimination Period: 60 Days 90 Days 180 Days 365 Days

Benefit Period: 2 Years 5 Years 10 Years To Age 67

Optional Riders:

<input type="checkbox"/> SIS (Social Insurance Substitute) Benefits Rider Do you have any dependent children age 17 or under? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered under the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hospital Confinement Indemnity Benefits Rider (check one option) <input type="checkbox"/> \$125 <input type="checkbox"/> \$250 <input type="checkbox"/> \$350 <input type="checkbox"/> \$500 <input type="checkbox"/> Specified Disease Benefits Rider (check one option) <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> Extended Proportionate Disability Benefits Rider <input type="checkbox"/> Future Insurability Option (FIO) Rider <input type="checkbox"/> Extended Own-Occ. Disability Defin. Amend. Rider <input type="checkbox"/> Cost-of-Living Adjustment (COLA) Rider
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If applying for Specified Disease Benefits Rider, complete additional health question below:
 Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. Yes No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

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 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 the application and any supplements shall become part of the applied for policy.

If the full initial premium is paid on the date of the completed application (or on the first premium deduction date), 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. I agree no temporary or interim insurance of any kind will be in effect, except as may be provided in any Conditional Receipt.

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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 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 Rediscovery

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

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

_____ Printed Name of Proposed Insured	_____ Spouse’s Printed Name (If Proposed Insured)	_____ If children are to be insured, their printed names
_____ Signature of Proposed Insured	_____ Signature of Spouse (If Proposed Insured)	_____ Signature of Parent or Guardian (If Proposed Insured is a Minor)
_____ 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, 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.

Conditional Receipt

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

Initial Premium paid by check

Money was collected - Received \$ _____ from _____ paid with an insurance application on _____, dated _____.
(person(s) proposed for insurance)

(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.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) \$50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: _____ Signed at: _____
City State

Signature of Proposed Insured

Signature of Producer

Signature of Producer

Conditional Receipt

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

Initial Premium paid by check

Money was collected - Received \$ _____ from _____ paid with an insurance application on _____, dated _____.
(person(s) proposed for insurance)

(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.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) \$50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: _____ Signed at: _____
City State

Signature of Proposed Insured

Signature of Producer

Signature of Producer

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result _____

Address _____

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured _____

Address _____

Signature of Proposed Insured or Parent/Guardian

Date Signed

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result _____

Address _____

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured _____

Address _____

Signature of Proposed Insured or Parent/Guardian

Date Signed

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. To the best of your knowledge and belief are you now using or during the last 10 years have you ever used 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. To the best of your knowledge and belief 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. To the best of your knowledge and belief 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. To the best of your knowledge and belief 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. To the best of your knowledge and belief 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. To the best of your knowledge have you ever been arrested for driving under the influence of alcohol? Yes No
 If "Yes," give dates and driver's license number. _____

7. To the best of your knowledge and belief 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.

OVERHEAD EXPENSE PROTECTION

SUMMARY OF COVERAGE

For Policy Form 151BE

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 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, 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 issued to persons of the same classification in your state.

Tax Deductible

Your Overhead Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings which allow certain business and professional men and women 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

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. 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.

Exceptions

Benefits are not payable for: loss beginning while the policy is not in force; loss resulting from suicide; loss resulting from air travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; loss caused by an act of declared or undeclared war; or childbirth, pregnancy or complications resulting therefrom.

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.

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 actual operating expenses incurred each month will be paid up to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense for one accident or sickness.

If benefits are payable for less than one month, the benefit payable for each day will be 1/30th of the average monthly operating expense as determined above.

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.

Suspension of Coverage While in an Armed Service and Subsequent Renewal

When you enter an armed service, coverage will be suspended for the period of such service. Upon your written request, any unearned premium will be returned. If you are in the service for less than five years, your policy may be renewed on the date your service ends if we receive your written application and premium within 60 days of your discharge. Your policy will be renewed on the same basis as before it was suspended and without restriction for preexisting conditions, except any that may be applied prior to the date of suspension.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 55%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.

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 Overhead Expense Protection Plan. 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.

ACCIDENT-ONLY SHORT-TERM DISABILITY INCOME INSURANCE COVERAGE – OUTLINE OF COVERAGE

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS REQUIRED DISCLOSURE STATEMENT

For Policy Form D83-21102 and D83-21103

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D83-21102 is 55%. The expected benefit ratio for Policy Form D83-21103 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

ACCIDENT DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from covered ACCIDENTS only, subject to any limitations set forth in this policy. This policy does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

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 Partial Disability benefits were payable; and the Benefit Period was not exhausted.

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 delivered or issued for delivery in New York to persons of the same Class. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

EXCLUSIONS

This policy pays benefits for loss resulting from covered Injuries only. We will not pay benefits for:

- (a) injuries that occur while this policy is not in force;
- (b) loss resulting from an act of declared or undeclared war;
- (c) loss caused by intentionally self-inflicted injury;
- (d) loss resulting from commission or attempted commission of a felony;
- (e) loss caused by suicide or attempted suicide;
- (f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician; or
- (g) loss for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law.

MILITARY SERVICE/ARMED FORCES EXCLUSION AND SUSPENSION OF COVERAGE

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium

within 60 days following active duty termination. Coverage will be retroactive to the date of the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

- (a) any loss resulting from an Injury or Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and
- (b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

BENEFITS REDUCTION WHEN ASSOCIATION GROUP MEMBERSHIP OR SELF-EMPLOYMENT ENDS (Policy Form D83-21103 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. 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. However, all benefits payable for loss beginning after such time will be reduced by 15%.

LONG-TERM DISABILITY INCOME INSURANCE COVERAGE – OUTLINE OF COVERAGE

For Policy Form D81-21098 and D81-21099

REQUIRED DISCLOSURE STATEMENT

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D81-21098 is 55%. The expected benefit ratio for Policy Form D81-21099 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from a covered accident or sickness, subject to any limitations set forth in the policy. This coverage does NOT provide basic hospital, basic medical-surgical, or major medical insurance as defined by the New York State Insurance Department.

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 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 Substitute 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 Substitute 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.

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 delivered or issued for delivery in New York 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. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

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 caused by intentionally self-inflicted injury;
- (d) loss resulting from commission or attempted commission of a felony;
- (e) loss caused by suicide or attempted suicide; or
- (f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of 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.

MILITARY SERVICE/ARMED FORCES EXCLUSION AND SUSPENSION OF COVERAGE

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium within 60 days following active duty termination. Coverage will be retroactive to the date the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

- (a) any loss resulting from an Injury or a Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and
- (b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

BENEFITS REDUCTION WHEN ASSOCIATION GROUP MEMBERSHIP OR SELF-EMPLOYMENT ENDS (Policy Form D81-21099 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. 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. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Optional Benefit – REQUIRED DISCLOSURE STATEMENT

SPECIFIED DISEASE BENEFITS RIDER

If you receive a Diagnosis of a Specified Disease Insured Condition, we will pay the Specified Disease Benefit. The Specified Disease Benefit is payable on a one-time basis. Once benefits are paid, this rider will terminate.

Specified Disease Insured Conditions include Alzheimer's Disease, Heart Attack (Myocardial Infarction), Life-Threatening Cancer (when first symptoms appear and first Diagnosis occurs more than 30 days after the Rider Date or the rider reinstatement date), Major Organ Transplant, Paralysis, Renal Failure and Stroke.

SPECIFIED DISEASE INSURANCE COVERAGE

This optional rider provides specified disease coverage ONLY, subject to any limitations set forth in the rider. This rider does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations shown in the policy apply to this rider.

READ YOUR RIDER CAREFULLY

This outline of coverage provides a very brief description of the important features of your rider. This is not the insurance contract and only the actual rider provisions will control. The rider itself sets forth in detail the rights and obligations of both you and Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR RIDER CAREFULLY!

The expected benefit ratio for this rider is 55%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, which averaged over all people with this rider.

SHORT-TERM DISABILITY INCOME INSURANCE – OUTLINE OF COVERAGE

For Policy Form D82-21100 and D82-21101

REQUIRED DISCLOSURE STATEMENT

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D82-21100 is 55%. The expected benefit ratio for Policy Form D82-21101 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

DISABILITY INCOME INSURANCE COVERAGE

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from a covered accident or sickness, subject to any limitations set forth in the policy. This policy does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

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 Partial 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.

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 delivered or issued for delivery in New York 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. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

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 caused by intentionally self-inflicted injury;
- (d) loss resulting from commission or attempted commission of a felony;
- (e) loss caused by suicide or attempted suicide;
- (f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;
- (g) loss for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law;
- (h) loss resulting from Substance Abuse; or
- (i) 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.

MILITARY SERVICE/ARMED FORCES EXCLUSION AND SUSPENSION OF COVERAGE

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium within 60 days following active duty termination. Coverage will be retroactive to the date the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

- (a) any loss resulting from an Injury or a Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and
- (b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

**BENEFIT REDUCTION WHEN
ASSOCIATION GROUP MEMBERSHIP
OR SELF-EMPLOYMENT ENDS
(Policy Form D82-21101 Only)**

This policy form was issued to you because you are self-employed or a member of a franchise/association group. 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. However, all benefits payable for loss beginning after such time will be reduced by 15%.

**Optional Benefit – REQUIRED
DISCLOSURE STATEMENT**

SPECIFIED DISEASE BENEFITS RIDER

If you receive a Diagnosis of a Specified Disease Insured Condition, we will pay the Specified Disease Benefit. The Specified Disease Benefit is payable on a one-time basis. Once benefits are paid, this rider will terminate.

Specified Disease Insured Conditions include Alzheimer’s Disease, Heart Attack (Myocardial Infarction), Life-Threatening Cancer (when first symptoms appear and first Diagnosis occurs more than 30 days after the Rider Date or rider reinstatement date), Major Organ Transplant, Paralysis, Renal Failure and Stroke.

SPECIFIED DISEASE INSURANCE COVERAGE

This optional rider provides specified disease coverage ONLY, subject to any limitations set forth in the rider. This rider does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations shown in the policy apply to this rider.

READ YOUR RIDER CAREFULLY

This outline of coverage provides a very brief description of the important features of your rider. This is not the insurance contract and only the actual rider provisions will control. The rider itself sets forth in detail the rights and obligations of both you and Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR RIDER CAREFULLY!

The expected benefit ratio for this rider is 55%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, which averaged over all people with this rider.