

Manager



Unit Manager

APPLICATION TO MUTUAL OF OMAHA INSURANCE COMPANY

SECTION 1

- 1. Print name (Title, First, Middle, Last, Area Code, Phone No.)
2. Residence address (No. and Street and Apt. No., City and State, ZIP Code)
3. Mailing address (No. and Street and Apt. No., City and State, ZIP Code)
4. Birth date (Month-Day-Year), Age, Sex, Height, Weight
5. Occupation, Duties
6. Social Security No.
7. Are you a citizen of the United States? If "No," do you have an Alien Registration Receipt Card?
Date of arrival in the United States (Mo., Yr.)

Table with 5 columns: Policy Form, Daily Benefit, Lifetime Maximum, Elimination Period, Premium. Includes rows for Rider No., Premium: Initial \$, Renewal \$, Renewal date, and Mode.

THIS BOX FOR ADMINISTRATIVE PURPOSES ONLY.

- 9. Premium paid \$
10. Is this insurance being purchased to replace any existing insurance? If "Yes," give details, including name of company, policy number and termination date
11. Full name of beneficiary Relationship (A beneficiary is needed if you are applying for a Benefit Account Rider)

SECTION 2

1. HAVE YOU EVER: (A) HAD, (B) BEEN ADVISED BY A PHYSICIAN THAT YOU HAD OR (C) RECEIVED ADVICE OR TREATMENT FOR: (CIRCLE CONDITIONS ANSWERED "YES" AND GIVE DETAILS IN 9 ON THE FOLLOWING PAGE.)

- (a) High blood pressure, chest pain, heart attack or stroke?
(b) Alzheimer's disease, seizures or convulsions, paralysis, mental or nervous disorder, or brain disease or disorder?
(c) Cancer, leukemia, malignant growth or any form of tumor?
(d) Diabetes, kidney disease or disorder, or any other disorder of the urinary system?

For Home Office Use Only

- Yes No
- (e) Asthma, emphysema or any lung disease, or other respiratory disorder?
- (f) Arthritis, neuritis, rheumatism, gout or any disease of, disorder or injury to the back, spine, bones, muscles or joints?
- (g) Alcoholism or drug abuse?
- (h) Any loss of hearing or loss of or partial loss of use of any eye, limb, hand or foot?
2. Have you ever been diagnosed as having or treated for the conditions of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
Circle condition(s) answered "Yes" and give details in 9 below.
3. Do you drive an automobile?
If "No," explain _____
4. Do you ever use a wheelchair, crutches, cane, walker or other mobility aid (i.e., braces, prosthesis, etc.)?
If "Yes," give details in 9 below.
5. Have you used medications for more than two weeks during the last 12 months?
If "Yes," give details in 9 below.
6. Within the past 12 months have you received medical treatment or been confined to a hospital, nursing home or convalescent facility?
If "Yes," give details in 9 below.
7. WITHIN THE PAST FIVE YEARS HAVE YOU HAD ANY MENTAL OR PHYSICAL DISORDER OR BODILY INJURY NOT LISTED ABOVE? YES NO IF "YES," GIVE DETAILS IN 9 BELOW.
8. List all doctors or health care providers usually consulted by you (if none, state "None"). _____ (Give names, addresses and date last seen in 9 below.)

9.

Ques. No.	Name	Condition, Injury, Symptoms of Ill Health or Findings of Examination (If Operation Performed, State Type)	Month and Year	Duration	Degree of Recovery	Name, Address and ZIP Code of Hospital and Attending Physician

10. CAN YOU DO EACH OF THE ACTIVITIES OF DAILY LIVING LISTED BELOW WITHOUT PHYSICAL OR MECHANICAL ASSISTANCE OR SUPERVISION? (IF ANY QUESTION IS ANSWERED "NO," GIVE DETAILS BELOW.)

- | | | | |
|--|---|------------------|---|
| | Yes No | | Yes No |
| (a) Get in or out of bed | <input type="checkbox"/> <input type="checkbox"/> | (d) Dress | <input type="checkbox"/> <input type="checkbox"/> |
| (b) Walk, clean house or go shopping | <input type="checkbox"/> <input type="checkbox"/> | (e) Toilet | <input type="checkbox"/> <input type="checkbox"/> |
| (c) Eat, prepare meals | <input type="checkbox"/> <input type="checkbox"/> | (f) Bathe | <input type="checkbox"/> <input type="checkbox"/> |

Details for "No" answers:

11. Are you living with another adult? Yes No

If "Yes": (a) for how long? _____ (b) age of the other adult? _____

(c) is the other adult in good health? Yes No (This question (11) is asked only to determine your eligibility for the two-person household discount.)

12. What accident and health insurance do you have in force or have you applied for? Give details below.

Name of Company	Policy Number	Description	Amount of Coverage

13. Do you reside in a "life care" or nursing care facility? Yes No If "Yes," give details below.

14. Have you used tobacco in the past year? Yes No If "Yes," cigarettes, cigars, pipe or other (describe). _____

15. I have been advised that I may designate a third party who will be notified if my policy is at risk of lapsing. I wish to exercise this right. Yes No If "Yes," list the name, address and telephone number of the person that you want the Company to contact below:

Name _____

Address _____

Phone No. _____

I represent that my above answers and statements are true and complete to the best of my knowledge and belief and agree that no insurance will be effective unless a policy is issued.

I understand that I may be insured under only one policy of this form at any one time. If insured under more than one, I may select the one that is to remain in effect. In the event of my death, the selection will be made by my beneficiary or my estate. We will return all premiums paid (less claims paid) for policies that do not remain in effect.

I agree that if I pay the full initial premium with my application, my eligibility for the policy applied for or any substitute policy will not be affected by any of the following changes: (a) in the underwriting standards of the Company occurring after the date of my application; (b) in my health that takes place after the application date if no medical examination is required; or (c) in my health that takes place after the date of a medical examination.

I further agree that if I pay the full initial premium with my application and am eligible for the policy applied for or any substitute policy in accordance with the underwriting standards of the Company in effect on the date of my application, the date of the policy will be the date of my application. If I am not eligible for the policy applied for or any substitute policy, I agree that no policy or temporary or interim insurance of any kind will be effective.

I/We certify that during an in-person interview with the proposed applicant, I/we have truly and accurately recorded in this application the information supplied by the applicant.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, MUTUAL OF OMAHA HAS THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.

NOTE: You must sign a Consumer Participation Agreement which will be given to New York State officials by the Company. This must be done in order to receive extended Medicaid coverage when the policy benefits are exhausted.

I have reviewed the current accident and health insurance coverage of the applicant and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs.

(Signature(s) of Licensed Resident Agent(s))

Dated at _____
(City) (State) (ZIP Code)

on _____, _____
(Month) (Day)

(Signature of Applicant)

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 Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations. We have contracts with persons and entities which act on our behalf which require them to maintain the confidentiality of the Personal Information.

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.

Inspection and Copying

I have the right to inspect or copy Personal Information disclosed under this authorization.

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
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that any of the Specified Companies has taken action in reliance on the authorization or the law allows any of the Specified Companies to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I, or my authorized representative, will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

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

Printed Name

If children are to be insured, their printed names

Signature of Proposed Insured

Date

Spouse's Printed Name (If Proposed Insured)

Signature of Spouse (If Proposed Insured)

Date

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

Date

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

APPLICATION REVIEW

I have reviewed this application for completeness.

Date _____ Reviewer's Name and Title _____

SECTION 3 BUYER'S STUDY INFORMATION (Agent — Please Complete)

- | | |
|--|--|
| <p>1. What is your source of business for this applicant?
 Applicant is or was a Mutual/United of Omaha client:
 <input type="checkbox"/> (a) Individual Health Policyowner
 <input type="checkbox"/> (b) Association Group Member
 <input type="checkbox"/> (c) Small Group Insured
 <input type="checkbox"/> (d) True Group Insured
 <input type="checkbox"/> (e) Life Policyowner
 <input type="checkbox"/> (f) Fund Owner
 <input type="checkbox"/> (g) OPAC Policyowner
 Applicant is a new Mutual of Omaha client:
 <input type="checkbox"/> (h) Immediate Family of Companies Policyowner
 <input type="checkbox"/> (i) Referred Lead from a Companies Policyowner
 <input type="checkbox"/> (j) Referred Lead from Other Source
 <input type="checkbox"/> (k) Direct Approach
 <input type="checkbox"/> (l) Advertising Lead
 <input type="checkbox"/> (m) Preapproach Letter
 <input type="checkbox"/> (n) Walk-in/Self
 <input type="checkbox"/> (o) Other _____</p> | <p>5. Which general occupation category best fits the applicant?
 <input type="checkbox"/> (a) Professional/ Tech./Teacher
 <input type="checkbox"/> (b) Manager/Exec./ Administrator
 <input type="checkbox"/> (c) Salesworker/ Retail Clerk
 <input type="checkbox"/> (d) Clerical Worker
 <input type="checkbox"/> (e) Craft/Kindred Worker
 <input type="checkbox"/> (f) Machine Operator/ Assembler
 <input type="checkbox"/> (g) Transport Equipment Oper.
 <input type="checkbox"/> (h) Nonfarm Laborers
 <input type="checkbox"/> (i) Service Worker
 <input type="checkbox"/> (j) Farm Worker
 <input type="checkbox"/> (k) Student
 <input type="checkbox"/> (l) Homemaker
 <input type="checkbox"/> (m) Retired</p> |
| <p>2. What is the household income of this applicant?
 <input type="checkbox"/> (a) Less than \$5,000
 <input type="checkbox"/> (b) \$5,000-\$9,999
 <input type="checkbox"/> (c) \$10,000-\$14,999
 <input type="checkbox"/> (d) \$15,000-\$19,999
 <input type="checkbox"/> (e) \$20,000-\$24,999
 <input type="checkbox"/> (f) \$25,000-\$34,999
 <input type="checkbox"/> (g) \$35,000-\$49,999
 <input type="checkbox"/> (h) \$50,000 or greater</p> | <p>6. What is the appropriate education level of the applicant?
 <input type="checkbox"/> (a) Elementary (8 years or less)
 <input type="checkbox"/> (b) Secondary (9-12 years)
 <input type="checkbox"/> (c) High School Graduate
 <input type="checkbox"/> (d) Some College (1-3 years)
 <input type="checkbox"/> (e) Bachelor's Degree (4 years)
 <input type="checkbox"/> (f) Graduate Degree</p> |
| <p>3. How many persons contribute to the household income?
 <input type="checkbox"/> (a) One
 <input type="checkbox"/> (b) Two
 <input type="checkbox"/> (c) Three or more</p> | <p>7. What is the applicant's marital status?
 <input type="checkbox"/> (a) Single
 <input type="checkbox"/> (b) Married
 <input type="checkbox"/> (c) Divorced
 <input type="checkbox"/> (d) Widowed</p> |
| <p>4. How many persons reside in the applicant's household?
 <input type="checkbox"/> (a) One
 <input type="checkbox"/> (b) Two
 <input type="checkbox"/> (c) Three
 <input type="checkbox"/> (d) Four
 <input type="checkbox"/> (e) Five
 <input type="checkbox"/> (f) Six or more</p> | <p>8. How long were you acquainted with applicant prior to sale?
 <input type="checkbox"/> (a) None
 <input type="checkbox"/> (b) Under one year
 <input type="checkbox"/> (c) One to five years
 <input type="checkbox"/> (d) Over five years</p> |
| | <p>9. How many interviews did it take to close the sale?
 <input type="checkbox"/> (a) One
 <input type="checkbox"/> (b) Two
 <input type="checkbox"/> (c) Three
 <input type="checkbox"/> (d) Four or more</p> |

Thank you for considering Mutual of Omaha Insurance Company as your insurance carrier. This is to inform you that as part of our procedure for processing your application an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your or your dependents' (if family insurance) character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

REQUEST FOR BANK SERVICE PLAN

To Mutual of Omaha Insurance Company: Please use your Bank Service Plan to make payments by withdrawing funds by check, draft or automatic debit entry from the account of:

S A M P L E A C T I V E C H E C K	_____	(Name as Shown on Account)	_____	(Insured/Applicant)
	_____	(Name of Financial Institution)	_____	(City and State)
	_____	(Account Number)	_____	(Branch (if any))

THIS PLAN INCLUDES THE FOLLOWING:

(1) _____	(Form)	_____	(Applicant)	(2) _____	(Form)	_____	(Applicant)
(3) _____	(Form)	_____	(Applicant)	(4) _____	(Form)	_____	(Applicant)

THE ABOVE APPLICATION(S) IS/ARE TO BE ADDED TO THE EXISTING BSP ACCOUNT THAT INCLUDES:

_____	(Existing BSP Policy Number)	_____	(Policyowner)
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SPECIFY DATE OF WITHDRAWALS	
<input type="checkbox"/> Withdraw on the 1st of month	<input type="checkbox"/> Withdraw on the 15th of month

This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.

<p>X _____</p> <p align="center">(Date)</p>	<p>X _____</p> <p align="center">(Authorized Signature as Shown on Account)</p>
<p><u>PLEASE SIGN AND DATE EACH PORTION.</u></p>	<p>X _____</p> <p align="center">(Joint Account or Other Authorized Signature)</p>

AUTHORIZATION TO WITHDRAW FUNDS
BY MUTUAL OF OMAHA INSURANCE COMPANY, Omaha, Nebraska

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As a convenience to me, I authorize you to pay and charge to my account, checks, drafts or automatic debit entries made upon my account by Mutual of Omaha Insurance Company, and payable to the order of Mutual of Omaha Insurance Company. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.

<p>X _____</p> <p align="center">(Date)</p>	<p>X _____</p> <p align="center">(Authorized Signature as Shown on Account)</p>
<p>X _____</p> <p align="center">(Date)</p>	<p>X _____</p> <p align="center">(Joint Account or Other Authorized Signature)</p>

PLEASE NOTE: The size of this form is adjustable from a 6 x 4 to a 5 x 3 card for your filing convenience.


See Indemnification Agreement on the reverse side.

MUTUAL OF OMAHA INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA • OMAHA, NEBRASKA 68175

To: The financial institution named on the reverse side.

So that you may comply with your depositor's request, this Company agrees:

- (a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by this Company and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of that insurance.
- (c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests or in any manner arising by reason of your participating in the foregoing plan of premium collection.



M. JANE HUERTER, Senior Executive Vice President and Corporate Secretary
MUTUAL OF OMAHA INSURANCE COMPANY
OMAHA, NEBRASKA

**AUTHORIZATION TO WITHDRAW FUNDS BY
MUTUAL OF OMAHA INSURANCE COMPANY**

As a convenience to me, I authorize you to pay and charge to my account, checks, drafts or automatic debit entries made upon my account by Mutual of Omaha Insurance Company and payable to the order of Mutual of Omaha Insurance Company. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive 15 days' written notice from me to revoke it.

X

(Date)

X

(Authorized Signature as Shown on Account)

X

(Joint Account or Other Authorized Signature)

ADDRESS INQUIRIES TO: MUTUAL OF OMAHA INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA — OMAHA, NEBRASKA 68175

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