

Thank you for your interest in **Mutual of Omaha** Medicare Supplement Insurance.

If you decide to apply, please mail your application to:

Medicare Supplement Specialists
15750 Woodgate Court
Sunrise, FL. 33326
Attn: Carlos Velazquez

You may also fax your application to: 1-888-550-3217 or email it to: quotes@medicaresupplementspecialists.com.

Please review the Outline of Coverage for benefit and rate information. Also available is the Guide to Health Insurance.

Please contact me with any questions.

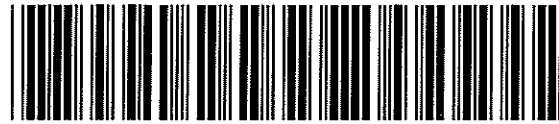
Best Regards,
Carlos Velazquez
Independent Agent
License No. 0613451
www.medicare-supplementspecialists.com
Phone: 954-384-8647

Agent Writing #

FAV Key _____ Auth # _____

Group # (if applicable) _____ Keyline _____

MUTUAL of OMAHA INSURANCE COMPANY



Application for Medicare Supplement Coverage

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

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G	Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G
Requested Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Requested Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>
Deliver Policy to Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>	Deliver Policy to Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP <input type="text"/>	State ZIP <input type="text"/>
Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/> (area code)	Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/> (area code)
E-mail Address	E-mail Address
Current Age _____	Current Age _____
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> mo day yr	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> mo day yr
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>	Social Security # <input type="text"/> - <input type="text"/> - <input type="text"/>
Height Ft <input type="text"/> In <input type="text"/> Weight Lbs <input type="text"/>	Height Ft <input type="text"/> In <input type="text"/> Weight Lbs <input type="text"/>

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B. Applicant Information (continued)

Applicant A

Applicant B

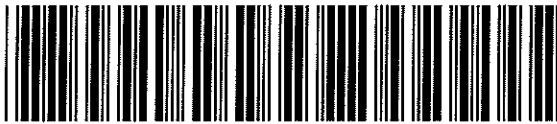
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Mutual of Omaha Insurance Company.

Receive statement online? Y N

Receive statement online? Y N

C. Medicare Information

Please reference your Medicare card to complete this section.



MEDICARE HEALTH INSURANCE 1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY JANE DOE	
MEDICARE CLAIM NUMBER 001-00-0000-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 07-01-2010 07-01-2010

Applicant A

Applicant B

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

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

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.

1. Does a member of your household:
- (a) with whom you have continuously resided for the last 12 months; or
 - (b) with whom you reside and to whom you are either married or in a civil union partnership; either have an existing Medicare supplement plan with, or are applying for coverage with Mutual of Omaha Insurance Company, Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?.....

Applicant A

Applicant B

Y N

Y N

2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)

Policy Number

Street Address

City/State/ZIP

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E. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:

	Applicant A	Applicant B
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," answer the following about this existing coverage:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

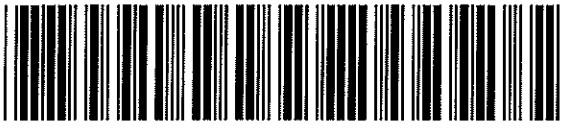
Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date..... Applicant A	<input type="text"/>	<input type="text"/>
Applicant B	<input type="text"/>	<input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	Applicant B
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this previous or existing coverage:		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A	START <input type="text"/>	START <input type="text"/>
	END <input type="text"/>	END <input type="text"/>
Applicant B	START <input type="text"/>	START <input type="text"/>
	END <input type="text"/>	END <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?..... Applicant A	<input type="text"/>	<input type="text"/>
Applicant B	<input type="text"/>	<input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Is your former Medicare supplement or Medicare Select policy certificate still available?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N



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

Check box(s) below if applicable

Applicant A	Applicant B
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

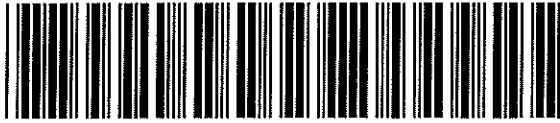
Please answer questions regarding other health insurance:

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

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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

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



Applicant A	START	____/____/____
	END	____/____/____
Applicant B	START	____/____/____
	END	____/____/____
Applicant A		____/____/____
Applicant B		____/____/____

(b) Planned date of termination/disenrollment?.....

Applicant A	____/____/____
Applicant B	____/____/____

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

<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
---	---

(d) Please state the reason for your disenrollment:

Applicant A _____

Applicant B _____

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

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

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

7. Are you applying during a guaranteed issue period?.....
(NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible.
If the answer above is "YES," attach proof of eligibility.)
8. Did you turn age 65 in the last six months?.....
9. Did you enroll in Medicare Part B in the last six months?.....

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Applicant A	____/____/____
Applicant B	____/____/____

If "YES," indicate your Medicare Part B effective date.....

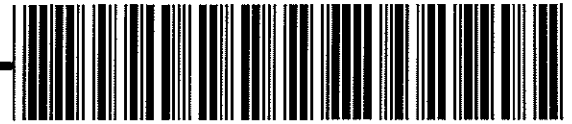
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IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

**If you are applying during an open enrollment or guaranteed issue period:
SKIP SECTIONS G & H and GO TO SECTION I.**

G. Health Information



For all plans, answer questions 10-21.

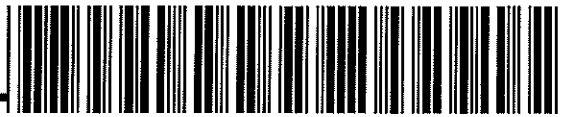
(If "YES" is answered to any of the following questions 10-19, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Are you currently receiving any occupational, speech or physical therapy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus, scleroderma or myasthenia gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have diabetes in addition to any of the following: retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, any heart disorder (including hypertension/high blood pressure), stroke, transient ischemic attack (TIA) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
19. Have you been hospital confined three or more times in the past two years for a same or similar condition?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
20. Have you taken any over-the-counter or prescription drugs in the past 24 months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
21. Have you used tobacco in any form in the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

(If YES, please complete the Medication Information sheet on the next page)

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H. Medication Information



If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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I. Agreement and Authorization



IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO Mutual of Omaha INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Mutual of Omaha Insurance Company. Unless revoked earlier, this authorization will remain in effect for 30 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I have the right to receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

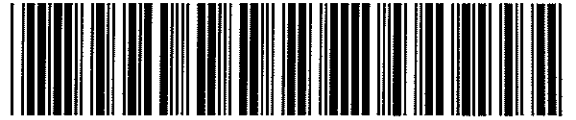
I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Mutual of Omaha Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

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Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant A's Signature

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant B's Signature (if applying)



J. Producer Comments (please attach a separate sheet if needed)

K. To be Completed by Producer

22. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).

(a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have truly and accurately recorded in the application the information supplied by the applicant(s)..... Y N

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

If you answered "NO" to any of the above statements, please explain why. _____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

_____ Date _____
Signature of Licensed Producer

Carlos Velazquez
Printed Name

0	5	1	8	7	5	4
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Agent Writing Number

_____ Date _____
Signature of Licensed Producer

Printed Name

--	--	--	--	--	--	--

Agent Writing Number

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I. Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2) <input checked="" type="checkbox"/> Initial premium amount (based on age at application date)..... 1. Paper Check (submit signed check with application)..... 2. Automated Bank Account Withdrawal..... Ongoing Premium Payments (Select option #1 or #2) 1. I want my payments automatically withdrawn from my bank account every month on (Circle date) 2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	Applicant A \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 st or 15 th every _____ months Insert 3, 6, or 12	Applicant B \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 st or 15 th every _____ months Insert 3, 6, or 12
	When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed in force, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks. Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. Ongoing withdrawals will begin once the policy is placed in force.	

Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is placed in force.**

Part II. Payor Information

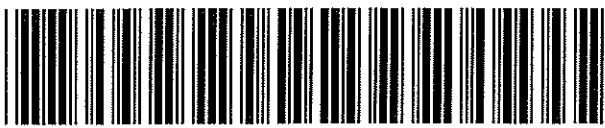
1. Account Owner Name , if different than applicant's..... 2. If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) Living Trust Power of Attorney or legal guardian (documentation required) Business owned by applicant or applicant's spouse	Applicant A _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Applicant B _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Part III. Account Information

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

Can attach voided check here	Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____	Applicant B <input type="checkbox"/> Same account as Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____
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- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.





Example:

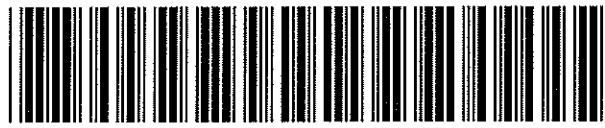
Account Holder Name	Do NOT include the check # in the Routing or Account Number.
John Doe Street Address Town, City ZIP Code	Check #1234 Date: _____
Pay to: _____	
Routing/Transfer Number	Account Number Dollars
Financial Institution Name & Address	
Memo to _____	Signed By: _____
⑆123456789⑆ 12345678 ⑆ 1234 ⑆	

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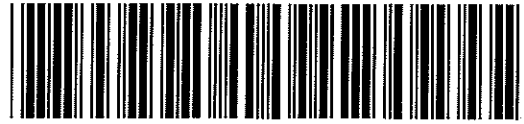
Part III. Account Information (continued)

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

Applicant A  _____ Authorized Signature as Shown on Account _____ Date	Applicant B  _____ Authorized Signature as Shown on Account _____ Date
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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by United of Omaha Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

Applicant	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

1. Health conditions which you may now have (preexisting conditions) may not be immediately or fully covered under the new policy if you have had your present policy for less than six months.
2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.



Signature of Agent, Broker or Other Representative*

Date

MUTUAL OF OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

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Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.