

Simple Instructions

1. **Print and complete the application**
2. **Include a voided check**
3. **Fax or mail your application to:**

Fax: 1-800-501-9222

or

Mail: For free postage, cut and paste this label onto your envelope.

BUSINESS REPLY MAIL		
FIRST-CLASS MAIL	PERMIT NO. 679	NORTHRIDGE, CA
POSTAGE WILL BE PAID BY ADDRESSEE		
HEALTH AND LIFE INSURANCE SERVICES APPLICATION PROCESSING CENTER 9510 SYLVIA AVENUE NORTHRIDGE, CA 91324-9904		

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



Questions? Call: 1-800-243-8100

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period: (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:



- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I	Standard	Class I	Class II	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2"	< 54	54 – 60	61 – 110	111 – 128	129 – 145	146 +
4' 3"	< 56	56 – 62	63 – 114	115 – 133	134 – 151	152 +
4' 4"	< 58	58 – 65	66 – 119	120 – 138	139 – 157	158 +
4' 5"	< 60	60 – 67	68 – 123	124 – 143	144 – 163	164 +
4' 6"	< 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7"	< 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8"	< 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9"	< 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4' 10"	< 72	72 – 81	82 – 148	149 – 172	173 – 196	197 +
4' 11"	< 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0"	< 77	77 – 87	88 – 158	159 – 184	185 – 209	210 +
5' 1"	< 80	80 – 89	90 – 164	165 – 190	191 – 216	217 +
5' 2"	< 83	83 – 92	93 – 169	170 – 196	197 – 224	225 +
5' 3"	< 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5' 4"	< 88	88 – 99	100 – 180	181 – 209	210 – 238	239 +
5' 5"	< 91	91 – 102	103 – 186	187 – 216	217 – 246	247 +
5' 6"	< 93	93 – 105	106 – 192	193 – 223	224 – 254	255 +
5' 7"	< 96	96 – 108	109 – 197	198 – 229	230 – 261	262 +
5' 8"	< 99	99 – 111	112 – 203	204 – 236	237 – 269	270 +
5' 9"	< 102	102 – 115	116 – 209	210 – 243	244 – 277	278 +
5' 10"	< 105	105 – 118	119 – 216	217 – 250	251 – 285	286 +
5' 11"	< 108	108 – 121	122 – 222	223 – 258	259 – 293	294 +
6' 0"	< 111	111 – 125	126 – 228	229 – 265	266 – 302	303 +
6' 1"	< 114	114 – 128	129 – 234	235 – 272	273 – 310	311 +
6' 2"	< 117	117 – 132	133 – 241	242 – 280	281 – 319	320 +
6' 3"	< 121	121 – 136	137 – 248	249 – 288	289 – 328	329 +
6' 4"	< 124	124 – 139	140 – 254	255 – 295	296 – 336	337 +
6' 5"	< 127	127 – 143	144 – 261	262 – 303	304 – 345	346 +
6' 6"	< 130	130 – 147	148 – 268	269 – 311	312 – 354	355 +
6' 7"	< 134	134 – 150	151 – 275	276 – 319	320 – 363	364 +
6' 8"	< 137	137 – 154	155 – 282	283 – 327	328 – 373	374 +
6' 9"	< 140	140 – 158	159 – 289	290 – 335	336 – 382	383 +
6' 10"	< 144	144 – 162	163 – 296	297 – 344	345 – 392	393 +
6' 11"	< 147	147 – 166	167 – 303	304 – 352	353 – 401	402 +
7' 0"	< 151	151 – 170	171 – 311	312 – 361	362 – 411	412 +
7' 1"	< 155	155 – 174	175 – 318	319 – 369	370 – 421	422 +
7' 2"	< 158	158 – 178	179 – 326	327 – 378	379 – 431	432 +
7' 3"	< 162	162 – 183	184 – 333	334 – 387	388 – 441	442 +
7' 4"	< 166	166 – 187	188 – 341	342 – 396	397 – 451	452 +

Medicare supplement insurance is underwritten by
UNITED OF OMAHA LIFE INSURANCE COMPANY
 A MUTUAL of OMAHA COMPANY
 Mutual of Omaha Plaza
 Omaha, Nebraska 68175
mutualofomaha.com

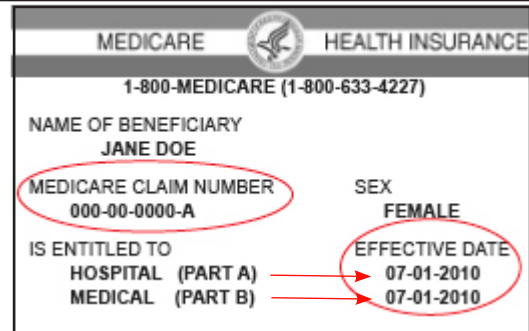


B. Applicant Information (continued)

Applicant A	Applicant B
Have you used tobacco in any form in the past 12 months? (If answered "No," you will be eligible for a discount on your premium.) <input type="checkbox"/> Y <input type="checkbox"/> N	Have you used tobacco in any form in the past 12 months? (If answered "No," you will be eligible for a discount on your premium.) <input type="checkbox"/> Y <input type="checkbox"/> N
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease?..... <input type="checkbox"/> Y <input type="checkbox"/> N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? <input type="checkbox"/> Y <input type="checkbox"/> N
<p>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 <u>not</u> 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 United of Omaha.</p>	
Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N	Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>
Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	Applicant A	Applicant B
1. Does a member of your household: <ul style="list-style-type: none"> (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married either have an existing Medicare supplement plan with, or are applying for coverage with United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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 that you had certain rights to buy such a policy such as open enrollment, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:

3. Are you covered for medical assistance through the state Medicaid or Medi-Cal program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," answer the following about this existing coverage:	Applicant A <input type="checkbox"/> Y <input type="checkbox"/> N	Applicant B <input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid or Medi-Cal 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 or Medi-Cal 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 insurance policy or certificate or health care service plan 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"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> /	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <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
Effective Date	Effective Date

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

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).....	Applicant A <input type="checkbox"/> Y <input type="checkbox"/> N	Applicant B <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"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> /	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> /
	Applicant A END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> /	Applicant B END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <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"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> /	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <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) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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



G. Health Information

For all plans, answer questions 10-18.

(If “Y” (YES) or “NS” (NOT SURE) is answered to any of the following questions 10-18, 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
12. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing (excluding HIV/AIDS) or any surgery that has not been performed?.....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
13. Within the past five years have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alzheimer’s Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Systemic Lupus or Myasthenia Gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
14. Within the past five years have you been treated for diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
15. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
16. 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?.	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
17. 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
18. 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"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS

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H. Medication Information

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

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 or Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid or Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid or Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid or Medi-Cal. If you are no longer entitled to Medicaid or Medi-Cal, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid or Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the 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 or Medi-Cal 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 Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free telephone number (1-800-927-HELP), your local HICAP office, or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).



I. Agreement and Authorization (continued)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED OF OMAHA LIFE 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, 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 United of Omaha. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United of Omaha Life 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 United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha 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 will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

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

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

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

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



Part I. Select Premium Payment Option

<p>Initial Premium (Select option #1 or #2) ✎ Initial premium amount (based on age at application date)</p> <p>1. Paper Check (submit signed check with application)..... 2. Automated Bank Account Withdrawal.....</p> <p>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).....</p>	<p>Applicant A</p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p style="text-align: center;">1st or 15th</p> <p>every _____ months Insert 3, 6, or 12</p>	<p>Applicant B</p> <p>\$ _____</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p style="text-align: center;">1st or 15th</p> <p>every _____ months Insert 3, 6, or 12</p>
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Part II. Payor Information

<p>Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account):</p> <p>1. Account Owner Name, if different than applicant's..... 2. Account Owner Relationship to applicant: Employer Living Trust Power of Attorney or legal guardian (documentation required) Business owned by applicant or applicant's spouse</p>	<p>Applicant A</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p>Applicant B</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>
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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)

<p>Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution _____</p> <p>Routing Number (9 digits on lower left side of check) _____</p> <p>Account Number (Do NOT use Debit/Credit Card numbers) _____</p> <p>Name as Shown on Account _____</p>	<p>Applicant B <input type="checkbox"/> Same account as Applicant A</p> <p>Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings</p> <p>Name of Financial Institution _____</p> <p>Routing Number (9 digits on lower left side of check) _____</p> <p>Account Number (Do NOT use Debit/Credit Card numbers) _____</p> <p>Name as Shown on Account _____</p>
--	--

Can attach voided check here

- 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 ⑆	

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for my 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 you, my financial institution, to pay from my account to United of Omaha any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

<p>✎ X _____ Authorized Signature as Shown on Account</p> <p>_____ Date</p>	<p>✎ X _____ Authorized Signature as Shown on Account</p> <p>_____ Date</p>
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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by United of Omaha Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.





If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to Applicant from the insurer and agent: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

Applicant	Applicant B
_____ Additional benefits that are:	_____ Additional benefits that are:
_____ No change in benefits, but lower premiums	_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums	_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D	_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
_____ Other reasons specified here:	_____ Other reasons specified here:
_____	_____
_____	_____
_____	_____

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

 _____ **Signature of Agent, Broker or Other Representative*** _____ **Date**
 UNITED OF OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature  	Signature  
Date	Date

*Signature not required for direct response sales.

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Guaranteed Issue and Open Enrollment Notice for California

Requirements for individuals who are eligible for Guaranteed Issue.

- (1) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.
- (2) Enrolled in a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following apply:
 - (a) The certification of the organization or plan has been terminated; or
 - (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or
 - (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary; or
 - (d) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible for a Medicare supplement policy issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement policy is available to the individual from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, the individual shall be eligible for a Medicare supplement policy issued by any issuer, if the Medicare Advantage plan in which the individual is enrolled does any of the following: increases the premium by 15 percent or more, increases physician, hospital, or drug copayments by 15 percent or more, reduces any benefits under the plan, or discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.
 - (e) Enrollment in a Medicare supplement contract from an issuer unaffiliated with the issuer of the Medicare Advantage plan in which the individual is enrolled shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual. Nothing in this section shall be construed to authorize an individual to enroll in a group Medicare supplement policy if the individual does not meet the eligibility requirements for the group; or
 - (f) The individual demonstrates, either of the following:
 - The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
 - The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - (g) The individual meets other exceptional conditions as the secretary may provide.
- (3) Individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider and circumstances exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.
- (4) Individual meets both of the following conditions:
 - (a) Individual is enrolled with any of the following:
 - An eligible organization under a contract of the Social Security Act (Medicare cost).
 - A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.
 - An organization under an agreement of the Social Security Act (health care prepayment plan).
 - An organization under a Medicare Select policy; or
 - (b) Enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).
- (5) Individual is enrolled under a Medicare supplement policy, and enrollment ceases because of any of the following circumstances:
 - (a) Insolvency of the issuer or bankruptcy of the non-issuer organization, or other involuntary termination of coverage or enrollment under the policy; or
 - (b) The issuer of the policy substantially violated a material provision of the policy; or
 - (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
- (6) Individual meets both of the following conditions:
 - (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any

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eligible organization under a contract of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider of the Social Security Act, or a Medicare Select policy; and

- (b) The subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment).
- (7) Individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.
- (8) Individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy.
- (9) During a period of guaranteed issuance of any Medicare supplement coverage, the applicant is not required to sign a HIPAA form.

Requirements for individuals who are eligible for Open Enrollment.

- (1) (a) A policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.
- (b) An issuer shall make available Medicare supplement benefit plans A, B, C, and F if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.
- (2) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.
- (3) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:
 - (a) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.
 - (b) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.
 - (c) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
- (4) An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.
- (5) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.
- (6) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

I have read the Guaranteed Issue and Open Enrollment Notice and understand that if I am eligible for Guarantee Issue, I am not required to provide health information on my application.



Agent's Signature

Date

Applicant		Applicant B	
Signature 		Signature 	
Date		Date	

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IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Guaranteed Issue and Open Enrollment Notice

24-Hour Meeting Notice

Premium Receipt / Notice of Information Practices

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by United of Omaha Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.



Statement to Applicant from the insurer and agent: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

Applicant	Applicant B
_____ Additional benefits that are: _____	_____ Additional benefits that are: _____
_____ No change in benefits, but lower premiums	_____ No change in benefits, but lower premiums
_____ Fewer benefits and lower premiums	_____ Fewer benefits and lower premiums
_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D	_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D
_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	_____ Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
_____ Other reasons specified here: _____ _____	_____ Other reasons specified here: _____ _____

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

 _____
Signature of Agent, Broker or Other Representative* Date

UNITED OF OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature 	Signature 
Date	Date

*Signature not required for direct response sales.

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Guaranteed Issue and Open Enrollment Notice for California

Requirements for individuals who are eligible for Guaranteed Issue.

- (1) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits.
- (2) Enrolled in a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following apply:
 - (a) The certification of the organization or plan has been terminated; or
 - (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or
 - (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary; or
 - (d) The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual. An individual shall be eligible for a Medicare supplement policy issued by the same issuer through which the individual was enrolled at the time the reduction, increase, or discontinuance described above occurs or, commencing January 1, 2007, for one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement policy is available to the individual from the same issuer, a subsidiary of the parent company of the issuer, or a network that contracts with the parent company of the issuer, the individual shall be eligible for a Medicare supplement policy issued by any issuer, if the Medicare Advantage plan in which the individual is enrolled does any of the following: increases the premium by 15 percent or more, increases physician, hospital, or drug copayments by 15 percent or more, reduces any benefits under the plan, or discontinues, for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to the individual.
 - (e) Enrollment in a Medicare supplement contract from an issuer unaffiliated with the issuer of the Medicare Advantage plan in which the individual is enrolled shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently furnishing services to the individual. Nothing in this section shall be construed to authorize an individual to enroll in a group Medicare supplement policy if the individual does not meet the eligibility requirements for the group; or
 - (f) The individual demonstrates, either of the following:
 - The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or
 - The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - (g) The individual meets other exceptional conditions as the secretary may provide.
- (3) Individual is 65 years of age or older, is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider and circumstances exist that would permit discontinuance of the individual's enrollment with the provider, if the individual were enrolled in a Medicare Advantage plan.
- (4) Individual meets both of the following conditions:
 - (a) Individual is enrolled with any of the following:
 - An eligible organization under a contract of the Social Security Act (Medicare cost).
 - A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.
 - An organization under an agreement of the Social Security Act (health care prepayment plan).
 - An organization under a Medicare Select policy; or
 - (b) Enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) or (3).
- (5) Individual is enrolled under a Medicare supplement policy, and enrollment ceases because of any of the following circumstances:
 - (a) Insolvency of the issuer or bankruptcy of the non-issuer organization, or other involuntary termination of coverage or enrollment under the policy; or
 - (b) The issuer of the policy substantially violated a material provision of the policy; or
 - (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
- (6) Individual meets both of the following conditions:
 - (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any

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eligible organization under a contract of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider of the Social Security Act, or a Medicare Select policy; and

- (b) The subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment).
- (7) Individual upon first becoming eligible for benefits under Medicare Part A at age 65 years of age, enrolls in a Medicare Advantage plan under Medicare Part C or with a PACE provider, and disenrolls from the plan or program not later than 12 months after the effective date of enrollment.
- (8) Individual while enrolled under a Medicare supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period, terminates enrollment in the Medicare supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy.
- (9) During a period of guaranteed issuance of any Medicare supplement coverage, the applicant is not required to sign a HIPAA form.

Requirements for individuals who are eligible for Open Enrollment.

- (1) (a) A policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.
- (b) An issuer shall make available Medicare supplement benefit plans A, B, C, and F if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.
- (2) An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment described in this section for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.
- (3) An individual enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:
 - (a) Receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer-sponsored health plan including an employer-sponsored retiree health plan.
 - (b) Receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan.
 - (c) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
- (4) An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.
- (5) An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.
- (6) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

I have read the Guaranteed Issue and Open Enrollment Notice and understand that if I am eligible for Guarantee Issue, I am not required to provide health information on my application.



Agent's Signature

Date

Applicant		Applicant B	
Signature 		Signature 	
Date		Date	

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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Dear _____

Thank you for agreeing to meet with me on _____
Date Time

During this meeting, or a follow-up meeting, we will be discussing the following:

A sales presentation on:

- Life insurance
- Annuities
- OTHER insurance _____

In Addition:

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

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

The following individuals will be coming to your home:

Name License #

Name License #

Sincerely,



United of Omaha Life Insurance Company Representative

Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company
Health Insurance Underwritten by Mutual of Omaha Insurance Company
Both at Mutual of Omaha Plaza, Omaha NE, 68175

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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Premium Receipt

All premiums must be made payable to United of Omaha Life Insurance Company.

Do not make check payable to the agent or leave the payee blank.

Applicant A


Received from _____

this ____ day of _____, _____

an application for Form _____ Policy

and/or Riders _____ and _____

Check for _____ Dollars.

 Agent _____

Applicant B


Received from _____

this ____ day of _____, _____

an application for Form _____ Policy

and/or Riders _____ and _____

Check for _____ Dollars.

 Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, United of Omaha Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.



Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

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

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

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

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