

Producer Name

Agent Writing Number or Social Security Number

Commission Share

Commission Code- Required only if you are not appointed or licensed or are changing brokerage firms



Form fields for Producer Name, Agent Writing Number, Commission Share, and Commission Code.

Preferred Method of Communication (Select one)

Form fields for communication preferences: Phone, Fax, Email, and Contact info.

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

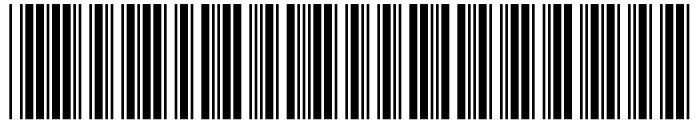
Application Submission Checklist – United World Medicare Supplement Coverage

- Provide Applicant with the Guide to Health Insurance for People with Medicare
Provide Applicant with the Outline of Coverage
Calculate the premium based on age at application date
Tobacco rates do not apply during open enrollment or guaranteed issue situations

Application (complete in full)

Sections A & B: Plan and Applicant Information

- Select plan
Enter Requested Effective Date
Indicate where the policy is to be mailed



Section C: Medicare Information

- Include applicant's Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Previous or Existing Coverage Information

- Please complete ALL questions in full

For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (M27788) to help identify eligibility.

Section E: Please answer all of the following questions

- If either Applicant A or B answered "YES" to question 5 OR BOTH questions 6 and 7 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information

- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization

- Make sure applicant(s) sign and date the application

Section J: To be Completed by Producer

- Make sure producer(s) sign and date the application

Complete the Method of Payment form (W27785) and return with the completed application

- Use premium determined by the Outline of Coverage
The full modal premium is collected at the time of application

Complete Replacement Notice (W24680\_0605) and leave a copy with the applicant (if applicable)

Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (W27790)

Provide Applicant with Guaranteed Issue and Open Enrollment Notice (W26254)

Note: An interviewer may call to verify/confirm the information provided on the application. This form is required if splitting commissions.

## 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)

Agent Writing #

FAV Key \_\_\_\_\_ Auth # \_\_\_\_\_

Group # (if applicable) \_\_\_\_\_ Keyline \_\_\_\_\_

# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA 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
<b>Plan (select one)</b> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <span style="margin-left: 100px;"><input type="checkbox"/> Plan F    <input type="checkbox"/> Plan G    <input type="checkbox"/> Plan M</span>	<b>Plan (select one)</b> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D <span style="margin-left: 100px;"><input type="checkbox"/> Plan F    <input type="checkbox"/> Plan G    <input type="checkbox"/> Plan M</span>
<b>Requested Effective Date</b> <input type="text"/> / <input type="text"/> / <input type="text"/>	<b>Requested Effective Date</b> <input type="text"/> / <input type="text"/> / <input type="text"/>
<b>Deliver Policy to</b> Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>	<b>Deliver Policy to</b> Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>

### B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State <span style="float: right;">ZIP</span>	State <span style="float: right;">ZIP</span>
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State <span style="float: right;">ZIP</span> <input type="text"/>	State <span style="float: right;">ZIP</span> <input type="text"/>
Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/> <small>(area code)</small>	Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/> <small>(area code)</small>
E-mail Address	E-mail Address
Current Age _____	Current Age _____
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> <small>mo                  day                  yr</small>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> <small>mo                  day                  yr</small>
<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"/>

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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 United World.

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 000-00-0000-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 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. 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
1. 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.) <b>If "YES," answer the following about this existing coverage:</b>	<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:

2. 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
<b>If "YES," answer the following about this existing coverage:</b>		
(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	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):

3. 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	Applicant B
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A	Applicant B
	START	START
	<input type="text"/>	<input type="text"/>
	END	END
	<input type="text"/>	<input type="text"/>
	Applicant B	Applicant B
	START	START
	<input type="text"/>	<input type="text"/>
	END	END
	<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	Applicant B
	<input type="text"/>	<input type="text"/>
	Applicant B	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) 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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- (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:**

4. 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 / /
- (b) Planned date of termination/disenrollment?.....
- Applicant A / /
- Applicant B / /
- (c) 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

**E. Please answer all of the following questions:**

To the Best of Your Knowledge and Belief:

5. Are you applying during a guaranteed issue period?.....  
(NOTE: Refer to Form W26254 to determine the definition of a guaranteed issue period. If the answer above is "YES," attach proof of eligibility.)
6. Did you turn age 65 in the last six months?.....
7. 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

If "YES," indicate your effective date.....

Applicant A / /

Applicant B / /

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**IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 5 OR BOTH QUESTIONS 6 AND 7 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.**



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



**F. Health Information**

**For all plans, answer questions 8-18.**

(If "YES" is answered to any of the following questions 8-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	<b>Applicant A</b>	<b>Applicant B</b>
8. 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
9. 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"/> Y <input type="checkbox"/> N
10. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. 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 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
12. Have you been diagnosed by a member of the medical profession with 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"/> Y <input type="checkbox"/> N
13. Do you have an implanted cardiac defibrillator? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. 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 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"/> 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
15. 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
16. 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
17. 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
18. Applicant A (Height) Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		
Applicant B (Height) Ft <input type="text"/> <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		

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NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.



# G. 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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# H. 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 UNITED WORLD 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 World. 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 World 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 World has taken action in reliance on the authorization or the law allows United World 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 World.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

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

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)

WA5977-36





# UNITED WORLD 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.**

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 World 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. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

<b>Applicant A</b>	<b>Applicant B</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)
_____	_____
_____	_____
_____	_____

If, you still wish to terminate your present policy or certificate 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 or certificate 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 World Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

### Applicant A

### Applicant B

Signature 	Signature 
Date	Date

\*Signature not required for direct response sales.

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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**

**Premium Receipt / Notice of Information Practices**

# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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

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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. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

<b>Applicant A</b>	<b>Applicant B</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)
_____	_____
_____	_____
_____	_____

If, you still wish to terminate your present policy or certificate 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 or certificate 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 World Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

<b>Applicant A</b>	<b>Applicant B</b>
Signature 	Signature 
Date	Date

\*Signature not required for direct response sales.

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# UNITED WORLD LIFE INSURANCE COMPANY

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## Guaranteed Issue and Open Enrollment Notice

### The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

- (a) Enrolled under an employee welfare benefit plan and the plan terminates or ceases to provide benefits or the individual is no longer eligible for the plan;
- (b) Enrolled in a Medicare Advantage plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
- (e) 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 Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost) (42 U.S.C.A. 1935mm), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851 (e) of the Social Security Act), or
- (f) Upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.
- (g) Enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the Insured Person terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy that is classified as a Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

If any of the definitions apply to you, please complete the Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

### Open Enrollment

An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this Commonwealth, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this section without regard to age. In the case of group policies, an issuer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

**Give This Copy To The Applicant**

# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Premium Receipt

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All premiums must be made payable to United World 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.

### Applicant B

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and \_\_\_\_\_  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

 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 World 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

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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 WORLD 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.**