Mutual of Omaha Insurance Company

APPLICATION for INDIVIDUAL DISABILITY INCOME

PENNSYLVANIA

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

INDIVIDUAL DISABILITY INCOME
Application Submission Checklist

☐ **Application**

1. Must be taken during an in-person interview.
2. Answer all questions completely.
3. Be sure to leave all applicable forms with the proposed insured.
4. Sign and Date in all places indicated.
5. See reverse side of this page for detailed information.

☐ **Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

☐ **Collect Premium Amount**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

☐ **Attach Copy of Quote (if available)**

☐ **Schedule Paramed Exam as Applicable**

American Para Professional Systems (APPS) 1-800-635-1677
Hooper Holmes (Portamedic) 1-800-765-1010
ExamOne 1-877-933-9261
Examination Management Services, Inc (EMSI) 1-800-872-3674
Superior Mobile Medics 1-800-898-3926

☐ **Initiate the Client Profile process with the Proposed Insured**
Call 1-800-775-3000

☐ **Indicate Underwriting Requirements Initiated or Completed**

- ☐ Client Profile Interview
- ☐ Blood Profile
- ☐ Physical Data
- ☐ Long Form
- ☐ MD Exam
- ☐ EKG
- ☐ Mammogram
- ☐ Urinalysis

☐ **Indicate Financial Requirements Completed**

- ☐ Financials are generally not required if applying for Short-Term Accident Only coverage up to $3,000.
- ☐ Individuals who have been self-employed less than 12 months must provide a Profit and Loss/Expense Statement.

☐ **Any Additional Information or Comments**

____

____

____

NOTE: BROKERAGE ONLY – Please list your "commission code" in the box on the first page of the application. This will help avoid delay in commission payment.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.

Part 1: APPLICATION

- Notify the applicant that a telephone interview will be conducted to obtain additional information and/or to verify application information.

Section A: General Questions/Other Coverage Information/Income Information

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.
- All details of other coverages (in force or being applied for) must be listed.
- Complete all income information in full and provide details in the area provided.

Section B: Accident Only Underwriting Information

- Complete all information in full and provide details in the area provided.

Section C: Short-Term, Long-Term or Business Operating Expense Underwriting Information

- Complete all information in full and provide details in the area provided.

Section D: Business Operating Expense Underwriting Information

- Complete all information in full and provide details in the area provided.

Section E: Plan Information

- Complete all details of plan selected and rider information.

Section F: Premium Information

- The total premium amount must be listed. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual BSP), and amount of initial and renewal premium.
- If PRD mode, complete the PRD Authorization form.

Section G: BSP Authorization

- Specify date premiums will be withdrawn.
- Attach check for the account from which premiums will be withdrawn.

Section H: Agreements

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

Part 2: ADMINISTRATIVE FORMS

Appendix 1: Authorization to Disclose Personal Information

- The HIPAA authorization is to be signed and returned with the application.

Appendix 2: Authorization to Receive Information From and Disclose Information to the MIB Group

- The MIB authorization is to be signed and returned with the application.

Appendix 3 : Agent/Producer Statement

- This is necessary information for the underwriting process.

Appendix 4 & 5: Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

Receipt and/or Temporary Health and Accident Insurance Agreement

- Detach and leave with proposed insured.

State–Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Replacement Notice – complete if applicable

- Complete and leave a copy with applicant (if applicable).

HIV Consent Form – complete if applicable

- Form must be signed and dated. Detach 1st copy and leave with Proposed Insured.

Drug, Alcohol Usage, Avocation, Foreign National and Foreign Travel Questionnaires – complete if applicable

- Complete all information in full, sign and date.

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By

Application For:

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

☐ Accident Only Disability Insurance
☐ Short-term Disability Insurance
☐ Long-Term Disability Insurance
☐ Business Operating Expense Disability Insurance

SECTION A — GENERAL INFORMATION - COMPLETE FOR ALL CASES

Proposed Insured Information

1. Proposed Insured's Name (First, Middle, Last) ______
2. Sex ☐ Female ☐ Male
3. Age ______ DOB ____/____/____
4. Birth State ______
5. Height (Ft & In) ______ Weight (Lbs) ______
6. Home Tel. Number (____) ______
   Daytime Tel. Number (____) ______
   Best Time to Call ______ ☐ A.M. ☐ P.M.
7. Legal Residence Address (Number, Street, City, State, Zip) ______
8. E-Mail Address (optional) ______
9. Mailing Address for Premium Notices (Number, Street, City, State, Zip) ______
10. Full name of beneficiary ______
    Relationship to Proposed Insured ______
11. Social Security Number ____-____-____
12. Drivers License Number ______
13. Are you a citizen of the United States?....... ☐ Yes ☐ No
    If "No," please include your Permanent Resident Card form I-551 (also known as an "Alien registration Receipt Card" or "Green Card") number ______ and Visa Type ______
    If not a citizen of the United States, have you resided in the United States at least 3 consecutive years?....... ☐ Yes ☐ No
14. Employer ______
    Address ______
    Business Phone Number ______
    Occupation ______
    List exact duties ______
15. How long have you been employed in your current position? ____Years ____Months
16. Proposed Insured's Employment Status:
    ☐ Employee (No Ownership)
    ☐ Sole Proprietor
    ☐ Partner in Partnership ___ % Ownership
    ☐ Shareholder in Sub "S" Corp. ___ % Ownership
    ☐ Owner of C – Corp. ___ % Ownership
    Number of Full-time Employees ____
    Do you have any part-time or off-season occupation?
    ☐ Yes ☐ No (If "Yes," describe duties) ______
17. Are you a member of an Association Group or Franchise?
    ☐ Yes ☐ No If "Yes," full name of organization ______
    Date joined (Mo./Yr.) ______

Other Coverage and Replacement Information

1. Are you covered under or eligible for the Federal Employee's Compensation Act (FERS or CSRS) or the Railroad Retirement Act?.......... ☐ Yes ☐ No
2. Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance?.... ☐ Yes ☐ No
   If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

3. **Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.**
   I am requesting termination of my Policy No. ______ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

Income Information

1. Income information (Attach financial records if required. See underwriting guide for details)

	Current Year	Prior Year
(a) Gross Annual Earned Income	$ ______	$ ______
(b) If self employed, net annual earned income from your occupation (after business expenses and before taxes)	$ ______	$ ______
(c) Bonus, First Year Commissions and other incentive payments	$ ______	$ ______
(d) Other Earned Income (Part-time, off-season, etc.)	$ ______	$ ______
Total	$ ______	$ ______

2. During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month? ☐ Yes ☐ No

   If "Yes," average over last 12 months $ ______

SECTION B Complete only if applying for Accident Only Disability Insurance

1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? ☐ Yes ☐ No
   (If "Yes," submit a Drug or Alcohol Use Questionnaire)
2. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? ☐ Yes ☐ No
   (If "Yes," submit an Avocation Questionnaire)
3. During the last 3 years, have you had your drivers license suspended or revoked? ☐ Yes ☐ No
   If "Yes," please provide details ______
4. During the last 3 years, have you received or been advised by a healthcare provider (including chiropractor) to have treatment for any injury, impairment or disability? ☐ Yes ☐ No
   If "Yes," give details below. (Attach a separate signed sheet if necessary.)

Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

SECTION C Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.

1. During the last 5 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 9.

- ☐ Kidney or Urinary Tract
- ☐ Cancer or Tumor
- ☐ Heart or Coronary Arteries
- ☐ Alcohol or Drug Abuse
- ☐ Liver or Hepatitis
- ☐ Stroke or Cerebral Vascular condition
- ☐ Diabetes or Glandular condition
- ☐ Psychological, Emotional or Psychiatric condition
- ☐ Upper or Lower Digestive Tract
- ☐ Spine, Neck or Back
- ☐ High Blood Pressure, Arteries or Veins
- ☐ Arthritis or Joints (including replacements)
- ☐ Anemia or Blood
- ☐ Lung or Breathing Problem
- ☐ Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
- ☐ Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)
- ☐ Chronic Fatigue Syndrome
- ☐ Skin or Connective Tissue
- ☐ Fibromyalgia or Myalgia
- ☐ Epstein-Barr Viral Infection
- ☐ **None of These**

SECTION C — Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance. - continued

2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? .... ☐ Yes ☐ No

3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)? .... ☐ Yes ☐ No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name (copy from pharmacy label, if applicable)
Dosage/Frequency
Date
Reason
Prescribing Physician (if applicable)
Phone Number (if applicable)

4. During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? .... ☐ Yes ☐ No

5. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? .... ☐ Yes ☐ No
(If "Yes," submit a Drug or Alcohol Use Questionnaire)

6. Have you:
(a) ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? .... ☐ Yes ☐ No
If "Yes," provide details ______________________________
____

(b) ever applied for or received disability benefits of any kind? .... ☐ Yes ☐ No
If "Yes," provide details ______________________________
____

7. Are you pregnant? .... ☐ Yes ☐ No

8. Other than previously answered, during the last 5 years have you (a) been advised to have any medical test or surgical operation that was not performed, or (b) had any medical test or surgical operation performed, or (c) gone to a hospital, doctors' office (including chiropractic), clinic, dispensary or sanatorium for observation, examination or treatment? .... ☐ Yes ☐ No

9. Complete this section to expand on questions 1 and 8 in Section C. (Attach a separate signed sheet if necessary.)

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

SECTION D — Complete only if applying for BUSINESS OPERATING EXPENSE Insurance

1. Is your business conducted at your place of residence? .... ☐ Yes ☐ No
If "Yes," what percent of your duties are performed outside of your place of residence? .... ____________ %

2. Date business established? .... ____/____/____

3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

Average Monthly Expenses:

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

SECTION E — PLAN INFORMATION

Accident Only Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period: ☐ 0 Days ☐ 7 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

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

Short-Term Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period Accident/Sickness: ☐ 0/7 Days ☐ 7 Days ☐ 0/14 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:
☐ Return of Premium Benefit Rider (check one option) ☐ 50% ☐ 80%
☐ Hospital Confinement Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500
☐ Critical Illness Benefits Rider (check one option) ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

Long-Term Disability Insurance

Base Monthly Benefit Amount $____________________ **SIS Monthly Benefit Amount $** ______________

Elimination Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

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

Optional Riders:
☐ SIS (Social Insurance Supplement) Benefits Rider
Do you have any dependent children age 17 or under?. ☐ Yes ☐ No
Are you covered under the Social Security Act?.............. ☐ Yes ☐ No
☐ Return of Premium Benefit Rider (check one option)
☐ 50% ☐ 80%
☐ Hospital Confinement Indemnity Benefits Rider (check one option)
☐ $125 ☐ $250 ☐ $350 ☐ $500
☐ Critical Illness Benefits Rider (check one option)
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

☐ Extended Proportionate Disability Benefits Rider
☐ Future Insurability Option (FIO) Rider
☐ Extended Own-Occ. Disability Defin. Amend. Rider
☐ Cost-of-Living Adjustment (COLA) Rider

Business Operating Expense Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Benefit Period: ☐ 12 Months ☐ 18 Months

SECTION F — PREMIUM COLLECTION

Amount Collected $ __________ Initial Premium $ __________ Renewal Premium $ __________

Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

☐ Bank Service Plan (BSP) - Complete 'Authorization to Withdraw Funds' (If BSP is selected, collect 2 months of premium.)

☐ Payroll Deduction

Add to Existing PRD – Group Number.. __________

First Deduction Date .... __________

Number of Deductions.. __________

Effective Date of Payroll Deduction .... __________

SECTION G — Complete only if Billing Mode is BSP

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")

As a convenience to me, I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

2. Attach your check from the account from which premiums will be withdrawn.

SECTION H — PLEASE READ AND SIGN

AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. (“MIB”) – The MIB Group, Inc. (“MIB”) is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

“Personal Information” means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to Mutual of Omaha Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize Mutual of Omaha Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

AGREEMENT – I, the undersigned, agree that (a) all answers in this application are true and complete (b) Mutual of Omaha Insurance Company will rely upon these answers to determine insurability, and (c) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the date of the policy will be the date of the application or the expiration of any replaced coverage, if later.

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, I must complete all required examinations and tests (medical, paramedical, laboratory), and Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests and any other information (such as an Attending Physician's Statement) that is requested by Mutual of Omaha Insurance Company to underwrite the application. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date. **If I am not eligible for the insurance applied for or any substitute policy, I agree that no policy of any kind will be in effect except for coverage provided by any Temporary Health and Accident Insurance Agreement.**

In no event will any benefits be paid for the same loss under both any Temporary Insurance Agreement and any policy issued from this application.

No Agent/Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

SECTION H PLEASE READ AND SIGN - continued

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

Notice to Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee Residents Only: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to District of Columbia/Pennsylvania Residents Only: 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.

Notice to Florida Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Kansas Residents Only: 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 as determined by a court of law.

Notice to New Jersey Residents Only: Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Notice to Oregon Residents Only: 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 may be crime and may subject such person to criminal and civil penalties.

Notice to Puerto Rico Residents Only: Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Notice to Tennessee Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Vermont Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Notice to Virginia Residents Only: Must include "may have violated state law" in the fraud statement. Therefore, use this fraud warning statement: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I have (a) read and understand the Agreement and Fraud Warning Section and any Receipt provided; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signature of Proposed Insured	Printed Name of Proposed Insured	Date
Signature of Payor as shown on bank account (if Billing Mode is BSP and Payor is other than Proposed Insured)	Printed Name of Payor	Date

I/We certify that during an in-person interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. .... ☐ Yes ☐ No

(If "No," please explain.) ____________________

Signature of Producer	Producer's Printed Name	Date
Office Name	Office Address	
Signature of Producer	Producer's Printed Name	Date
Office Name	Office Address	

Appendix 1 Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

Purposes

The Personal Information will be used to determine my or my children's eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

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

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

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

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

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

Meanings of Terms

"MIB Group, Inc. (MIB)" means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Receive and Disclose

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

____

____

______________________________ Signature of Proposed Insured

______________________________ Date

______________________________ Signature of Spouse (If Proposed Insured)

______________________________ Date

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

______________________________ Date

Appendix 3 Agent/Producer Statement

1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.)............ ☐ Yes ☐ No

2 Has a medical examination of the Proposed Insured been scheduled?............ ☐ Yes ☐ No

If "Yes," when? ____________________ By ____________________

3 Has the client profile interview been completed?............ ☐ Yes ☐ No

If "No," the client profile interview has been scheduled for __________ (Date) and __________ (Time (Please circle –Eastern, Central, Mountain or Pacific))

4 Did you give the Notice of Information Practices to the Proposed Insured?............ ☐ Yes ☐ No

Date __________ (Mo./Day/Yr.) ____________________ (Agent/Producer's Signature) ____________________ (Agent/Producer's Signature)

Agent/Producer Information:

Agent/Producer Name ____________________ Agent/Producer Social Security Number ____________________

Comm. % Share ____________________ Agent/Producer Phone Number (______) (Area Code) ____________________

Agent/Producer E-mail Address ____________________

Agent/Producer's Stamp ____________________ Agent/Producer's License/ID Number ____________________

Agent/Producer Name ____________________ Agent/Producer Social Security Number ____________________

Comm. % Share ____________________ Agent/Producer Phone Number (______) (Area Code) ____________________

Agent/Producer E-mail Address ____________________

Agent/Producer's Stamp ____________________ Agent/Producer's License/ID Number ____________________

Appendix 4 — Mutual of Omaha Insurance Company
Notice of Information Practices

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

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. 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: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

M26977

Appendix 5 — Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734

In compliance with applicable law, Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

M26978_0809

Remove Notices and Give to Proposed Insured

All checks for premiums must be made payable to Mutual of Omaha Insurance Company. Do not make checks payable to the producer or leave the payee blank.

Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for ______________________

In consideration of the application and payment of $ ______________________ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed; or
   (c) The date this Agreement is signed by both parties.
2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
   (a) 90 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy/certificate applied for; or
   (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
   (d) The date the premium refund is mailed; or
   (e) The date Mutual mails notice of termination of coverage.
3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**
4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**
6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor dies the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this ____________ day of ________________, _______at ____
(Month) (Year) City State ZIP Code

____________________ ____________________ ____________________
Agent/Producer's Signature Signature of Proposed Insured Please Print Name

1– Applicant Copy 2 – Company Copy

All checks for premiums must be made payable to Mutual of Omaha Insurance Company. Do not make checks payable to the producer or leave the payee blank.

Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for ____________________

In consideration of the application and payment of $ ____________________ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed; or
   (c) The date this Agreement is signed by both parties.
2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
   (a) 90 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy/certificate applied for; or
   (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
   (d) The date the premium refund is mailed; or
   (e) The date Mutual mails notice of termination of coverage.
3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**
4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**
5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**
6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor dies the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this __________ day of ______________, ______at ____
(Month) (Year) City State ZIP Code

______________________________ ______________________________ ______________________________
Agent/Producer's Signature Signature of Proposed Insured Please Print Name

1– Applicant Copy 2 – Company Copy

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical 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, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on ______________________________.
Date

Witness ______________________________ ______________________________
Writing Agent Applicant’s Signature

1st Copy – Applicant 2nd Copy– Company

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical 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, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on ______________________________.
Date

Witness ______________________________ ______________________________
Writing Agent Applicant's Signature

1st Copy – Applicant 2nd Copy – Company

M92847_1002

HIV Test
Informed Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test results. This may include declining your application, charging an increased premium or making other changes in your coverage. A series of tests will be performed by a licensed laboratory using a medically accepted procedure.

Meaning of Test Results

The test is not for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS and shows whether you have been exposed to the virus. Positive test results do not mean you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive test results may cause you significant anxiety. It will also adversely affect your insurance application.

Pretesting Consideration

Many public health organizations have recommended that before taking an AIDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on their behalf or to outside legal counsel who needs such information to effectively represent them in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. A generic code which signifies only a nonspecific test abnormality may be reported to the Medical Information Bureau (MIB, Inc.), if the results are other than normal.

PA Department of Health
Division of HIV/AIDS
ATTN: Insurance Information Section
Health and Welfare Building
P.O. Box 90
Harrisburg, PA 17108

Allegheny County
Tim Curges
Allegheny County Health Department
Insurance Notification Information
3441 Forbes Avenue
Pittsburgh, PA 15213

Allentown City
Vicky Kistler, M.Ed.
Communicable Disease Manager
Allentown Health Bureau
245 North Sixth Street
Allentown, PA 18102

Bethlehem City
Jose Cruz
AIDS Prevention Coordinator
Bethlehem Bureau of Health
10 East Church Street
Bethlehem, PA 18018

Bucks County
Bucks County Department of Health
Counseling & Testing Section
Health Building
Neshaminy Manor Center
Doylestown, PA 18901

Chester County
Elizabeth Walls or Sandra Schwartz
Chester County Health Department
Bureau of Personal Health Services
601 Westtown Road, Suite 180
P.O. Box 2747
West Chester, PA 19380-0990

Erie County
Kathy Fatica
Erie County Department of Health
606 West 2nd Street
Erie, PA 16507

Montgomery County
Anita Culver
Montgomery County Health Department
Human Services Center
1430 DeKalb Street
P.O. Box 311
Norristown, PA 19404-0311

Philadelphia
Barbara Wills-Hooks
City of Philadelphia
Department of Public Health
Division of Disease Control
500 South Broad Street
Philadelphia, PA 19146

Wilkes Barre City
Patricia McNulty
Wilkes Barre City Health Department
16 East Northampton Street
Wilkes Barre, PA 18701

York City
Maria Deffley
York City Bureau of Health
One Market Way West, 3rd Floor
P.O. Box 509
York, PA 17401

MLU18199 1-01

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

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

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive, you are entitled to that information. However, because a trained person should deliver that information so that you can understand clearly what the test results mean, you are required to list a physician, a local health department or a local community-based organization so that they may tell you the result, explain its meaning and provide post-test counseling.

Name of Physician/Health Care Agency____

Address____

____

You are required by law to designate to whom a positive test result shall be sent. If you do not know who to select, you may refer to the accompanying list and select the agency to whom you wish results to be forwarded.

Consent

I have read and I understand this Informed Consent Form. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of my blood and/or other bodily fluids for HIV antibodies, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date________________________ ____

Signature of Proposed Insured

____

Signature of Agent/Witness

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

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

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive, you are entitled to that information. However, because a trained person should deliver that information so that you can understand clearly what the test results mean, you are required to list a physician, a local health department or a local community-based organization so that they may tell you the result, explain its meaning and provide post-test counseling.

Name of Physician/Health Care Agency______________________________

Address____

____

You are required by law to designate to whom a positive test result shall be sent. If you do not know who to select, you may refer to the accompanying list and select the agency to whom you wish results to be forwarded.

Consent

I have read and I understand this Informed Consent Form. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of my blood and/or other bodily fluids for HIV antibodies, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date____________________ ______________________________

Signature of Proposed Insured

____

Signature of Agent/Witness

Drug Usage Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

1. Name of Proposed Insured ______________________ Date of Birth ____________
Please Print

2A. Are you now using or have you used during the last 5 years any of the following drugs:

	Yes	No
(a) Opium derivatives: Heroin, Morphine, Demerol, Methadone, Codeine, Percodan, Dilaudid	☐	☐
(b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital	☐	☐
(c) Marijuana: Hashish, Cannabis	☐	☐
(d) Amphetamines: Benzedrine, Dexedrine, Methedrine, Preludin	☐	☐
(e) Cocaine, Crack	☐	☐
(f) Hallucinogens: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP	☐	☐
(g) Sedatives and Tranquilizers: Librium, Valium, Quaalude, Dalmane, Placidyl	☐	☐

2B. Were any of the above prescribed by a physician? ☐ Yes ☐ No If "Yes," which? ____________

3. If "Yes" answers in 2A or 2B, please give details.

Type	Usual Quantity	Frequency of Use	How Taken (Oral, Injection, Inhaled, Smoked, Etc.)	Date: From — To

4. Except those prescribed by a physician, are you now using or have you used during the last 5 years any other drugs not listed in number 2 or 3 above? ☐ Yes ☐ No If "Yes," explain ____________

5. During the last 5 years have you ever sought medical treatment because of drug usage? ☐ Yes ☐No

If "Yes," state dates and names of doctors and institutions consulted ____________

6. Please indicate any additional relevant information ____________

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at ____________ the ______ day of ______ , ______

Witness ____________ Signature of Proposed Insured ____________

M25816-36

Alcohol Use Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

Name of Proposed Insured ______________________________ Date of Birth ______________
Please Print

1. Do you presently use alcoholic beverages? ☐ Yes ☐ No If "No," date of last drink. ______________
If "Yes," please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. During the last 5 years did you ever drink substantially more than at present? ☐ Yes ☐ No
If "Yes," during what time period?

Dates: From ______________________ To ______________________
Please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Why did you change your drinking habits? ______________________________

____

3. Are you active in Alcoholics Anonymous or other recovery groups? ☐ Yes ☐ No How long? ______________

4. During the last 5 years have you ever consulted a doctor or received treatment because of your alcohol use? ☐ Yes ☐ No

If "Yes," indicate name and address of any doctor, hospital or treatment center and dates of treatment ______________

____

____

5. During the last 5 years have you ever taken, Antabuse or any other medication to control your drinking?
☐ Yes ☐ No If "Yes," please indicate date last used and name of doctor who prescribed it ______________

____

6. During the last 5 years have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No
If "Yes," give dates and driver's license number ______________________________

____

7. Have you ever used any other drugs, except over-the-counter drugs or those prescribed by a physician?
☐ Yes ☐ No (If answered "Yes," please complete Drug Usage Questionnaire.)

8 Remarks ____

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at ______________________________ the ____________ day of ____________ , __________

______________________________ ______________________________
Witness Signature of Proposed Insured

M25817-36

Avocation Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

Name of Proposed Insured ______________________________ Date of Birth ______________
Please Print

1. **Type of Avocation:**

   - ☐ Motorcycle Racing
   - ☐ Auto Racing
   - ☐ Boat Racing
   - ☐ Stunt Driving
   - ☐ Aircraft Piloting
   - ☐ Rodeo Activities
   - ☐ Rock/Mountain Climbing
   - ☐ Sky Diving
   - ☐ Scuba Diving
   - ☐ Other______________________________

2. How many times per year do you participate in this activity?______________________________

3. Do you plan to continue participating in this activity in the future? ☐ Yes ☐ No

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at ______________________________ the __________ day of __________ , __________

______________________________ ______________________________
Signature of Witness Signature of Proposed Insured

Foreign National and Foreign Travel Questionnaire

To be completed by Proposed Insured(s) or Policyowner(s) – Please attach an additional sheet of paper if necessary

1 Are you a U.S. citizen? ☐ Yes ☐ No
(If "Yes," proceed to Question 2.)

(a) Are you a Permanent Resident (holder of a Permanent Resident Card)? ☐ Yes ☐ No

(1) If "Yes," please list your Permanent Resident Card Number: ____________

(2) If "No," please list the type of visa you hold: ________ How long have you lived in the United States? ________

(b) Please provide your full name as stated on the Permanent Resident Card or Visa: ____________

(c) Date of issue on your Permanent Resident Card or Visa: ____________

(d) Date of expiration on your Permanent Resident Card: ____________

(e) Country of Birth: ____________

(f) Do you own a home in the United States? ☐ Yes ☐ No
If "Yes," please provide the address: ____________

(g) Do you own a home in a foreign country? ☐ Yes ☐ No
If "Yes," please provide the address: ____________

(h) If married, does your family live with you in the United States? ☐ Yes ☐ No

2 Are you employed in the United States? ☐ Yes ☐ No

(a) If "Yes," please provide the name and address of your employer and describe the duties you perform. ____________

(b) If "No," please provide source(s) of income while living in the United States. ____________

3 Do you plan to travel outside of the United States in the next two years? ☐ Yes ☐ No
(If "Yes," please answer the following questions below:)

(a) Where do you plan to travel? ____________

(b) What is the purpose of travel? ☐ Business ☐ Pleasure

(c) How often? ____________

(d) Average period of time for each trip: ____________

(e) What was the date of your last trip? ____________

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

Signature(s) of Proposed Insured(s) ____________ Date ________

Signature(s) of Policyowner(s) ____________ Date ________

Producer Statement: In the presence of the insured(s) I have asked each question as written and have recorded the answers completely and accurately. If question 1 was answered "No," I have seen the proposed insured(s) or policyowner(s) Permanent Resident Card ☐ Yes ☐ No

If "No," please provide explanation. ____________

Signature(s) of Producer(s) ____________ Date ________