United of Omaha Life Insurance Company
A Mutual *of* Omaha Company
P.O. Box 3608 Omaha, Nebraska 68103-3608

Application Submission Checklist To United of Omaha For Medicare Supplement Coverage – ILLINOIS

THIS APPLICATION MUST BE USED TO WRITE UNITED OF OMAHA MEDICARE SUPPLEMENT PRODUCTS

☐ **Application**

1. Complete "Plan Information" Box.
2. Refer to the Outline of Coverage for policy forms.
3. Answer all questions in full.
4. **Applicants applying for Plan N:**
   - during an Open Enrollment or Guaranteed Issue period should SKIP SECTIONS 4 & 5 AND GO TO SECTION 6.
   - outside of an Open Enrollment or Guaranteed Issue period and are **REPLACING** other coverage should SKIP SECTION 4 and COMPLETE SECTIONS 5 & 6.
   - outside of an Open Enrollment or Guaranteed Issue period and are **NOT REPLACING** other coverage should COMPLETE SECTION 4 THEN GO TO SECTION 6.
5. Sign and Date in all places indicated.
6. Be sure to leave all applicable forms with the proposed insured.
7. See reverse side of this page for additional detailed information.

☐ **Collect Premium Amount**

- The full modal premium is collected at the time of application.
- Calculate the premium based on age at time of application.
- Tobacco rates do not apply during Open Enrollment or Guarantee Issue situations.
- Follow instructions on page 1 of **Calculate Your Premium form (UC6582_0208)** to calculate the premium.

☐ **Provide Client with Buyer's Guide**

☐ **Provide Client with Outline of Coverage**

☐ **Complete Producer Information page**

☐ **If applicable, complete the Authorization for Electronic Funds Transfer form (ACH/BSP form U7535_0409) and return with the completed application**

- Withdrawal of the initial premium payment will occur when the application is processed.

☐ **Provide Client with Conditional Receipt signed by agent (if applicable), and provide Client with Notice of Information Practices**

☐ **Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form U7566_0610). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**

☐ **Complete Replacement Notice (U7563_IL) and leave a copy with the applicant (if applicable)**

☐ **Complete Medicare supplement Checklist - Illinois (U8250_IL_0011) and leave a copy with the applicant.**

Please provide additional information and comments in the space provided on the application.

Note: An interviewer may call to verify/confirm the information provided on the application.

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.

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.

1. Application – Agent Completes in Full: (please print)

"Plan Information" Box

- Policy Form
- Requested Effective Date
- Premium Collected (Amount) - Follow instructions on page 1 of Calculate Your Premium form (UC6582_0208) to calculate the premium. Complete the form for Applicants A & B (if applying) return with the application.
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, B=Automatic Funds Withdraw, or ACH=Automated Clearing House)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
  *Direct Monthly billing not available

Section 1 "General Information"–

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant's current age at time of application.
- The applicant's Social Security number as indicated from applicant's Social Security Card.
- For applicants already covered by Medicare, include applicant's Medicare number on the application as indicated from the applicant's Medicare Health Insurance Card. 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.
- The applicant's current Height in feet and inches and Weight in pounds.

Sections 2 and 3 "Existing Coverage Information"–

- Please complete all questions in full.
- If the applicant is not covered by Medicare, indicate "Eligibility Date" and "Date of Enrollment".
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
  – Name of Company
  – Policy/Certificate Number
  – Plan
  – Issue Date
  – Termination/Disenrollment Date
  – Kind of Policy

NOTE: An interviewer may call to verify/confirm the information provided on the application.

2. Administrative Forms

Producer/Agent Information

- Be sure to include your Social Security number and commission code.
  NOTE: This information is necessary for the underwriting process and commission payment.
- Include your telephone number, e-mail address and FAX number for contact purposes.

Authorization for Electronic Funds Transfer by United of Omaha Life Insurance Company (ACH/BSP) –
If applicant chooses to pay premium by ACH/BSP, complete this form accurately and in its entirety and return with the application.

- **Option A** - Pay all premiums (1st & montly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium MUST be submitted with the application
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment.

Conditional Receipt and Notice of Information Practices

- Complete and sign the receipt (if applicable), detach entire page and leave with applicant.

Authorization To Disclose Personal Information (HIPAA)

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.

Replacement Notice – complete if applicable

- Complete form including signature and date.
- Leave a copy with applicant (if applicable).

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Group number (if applicable):_____

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Application For Medicare Supplement Coverage

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By

MEDICARE SUPPLEMENT PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT **Policy Form**	**APPLICANT B** **Policy Form**
Requested Effective Date	Requested Effective Date
Premium Collected (**based on age at application date**) $	Premium Collected (**based on age at application date**) $
Initial Mode ☐**A,** ☐**S,** ☐**Q,** ☐**B,**☐**ACH**	Initial Mode ☐**A,** ☐**S,** ☐**Q,** ☐**B,**☐**ACH**
Renewal $	Renewal $
Renewal Mode ☐**A,** ☐**S,**☐**Q,** ☐**B** (monthly not available)	Renewal Mode ☐**A,** ☐**S,**☐**Q,** ☐**B,** (monthly not available)

1. PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	**Applicant B**
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth_____/____/_____ mo day yr	Current Age _____ Date of Birth_____/____/_____ mo day yr
Male ☐ Female ☐	Male ☐ Female ☐
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____
Have you used tobacco in any form in the past 12 months? .....Yes ☐ No ☐	Have you used tobacco in any form in the past 12 months? .....Yes ☐ No ☐

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	Applicant	Applicant B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage?	Yes ☐ No ☐	Yes ☐ No ☐
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part A effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," what is your eligibility date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
2. Are you covered under Medicare Part B?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part B effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," indicate date you plan to enroll. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
3. Did you turn age 65 in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," indicate your effective date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, 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.**

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____/____/____	Issue Date ____/____/____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes ☐ No ☐	Yes ☐ No ☐
(c) If "YES," indicate termination date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.		
START ____/____/____ END ____/____/____ (Applicant) / START ____/____/____ END ____/____/____ (Applicant B)		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐
(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)		
(d) Planned date of termination/disenrollment? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

	Applicant	Applicant B
(e) Was this your first time in this type of Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.)	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company and what kind of policy? (List below.)		

Applicant		Applicant B	
Name of Company	Kind of Policy	Name of Company	Kind of Policy

(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.
START ____/____/____ (Applicant) END ____/____/____ / START ____/____/____ (Applicant B) END ____/____/____

(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

(d) Planned date of termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

5. 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.)	Yes ☐ No ☐	Yes ☐ No ☐
If "YES,"		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes ☐ No ☐	Yes ☐ No ☐
6. Producers shall list any other health insurance policies they have sold to the applicant.		
(a) List policies sold which are still in force.		

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies sold in the past five (5) years which are no longer in force.

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

4. IF APPLYING FOR plans other than Plan N:

- **If you are applying during an Open Enrollment or Guaranteed Issue period, SKIP SECTIONS 4 & 5 and GO TO SECTION 6.**
- **If you are applying outside of an Open Enrollment or Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and then GO TO SECTION 6.**

IF APPLYING FOR Plan N:

- **If you are applying during an Open Enrollment or Guaranteed Issue period, SKIP SECTIONS 4 & 5 and GO TO SECTION 6.**
- **If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and are REPLACING other coverage, SKIP SECTION 4 and COMPLETE SECTIONS 5 & 6.**
- **If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and do NOT currently have a Medicare supplement, Medicare Advantage, or employer group health plan, PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and then SKIP TO SECTION 6.**

If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

To the Best of Your Knowledge:	APPLICANT	APPLICANT B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been diagnosed or treated by a physician or licensed medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do **not** have diabetes, this question should be answered "NO".	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☐	Yes ☐ No ☐
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes ☐ No ☐	Yes ☐ No ☐
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the past two years have you been treated for degenerative bone disease, crippling/ disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes ☐ No ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes ☐ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

5. IF YOU ARE APPLYING FOR MEDICARE SUPPLEMENT PLAN N OUTSIDE OF AN OPEN ENROLLMENT OR GUARANTEED ISSUE PERIOD AND ARE REPLACING OTHER COVERAGE (including Medicare supplement, Medicare Advantage, group medical, etc.) – Please Answer These REQUIRED Questions. If you answer "YES" to any of the following questions 1-4, you will NOT be eligible for coverage.

	APPLICANT	APPLICANT B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you been diagnosed with any of the following?		
A. Kidney disease requiring dialysis?	Yes ☐ No ☐	Yes ☐ No ☐
B. Chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
4. Within the past two years have you been treated for or been advised by a physician to have treatment for a heart attack; heart, coronary, or carotid artery disease; or heart rhythm disorders?	Yes ☐ No ☐	Yes ☐ No ☐
5. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes ☐ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
_____	Medication Name (copy off pharmacy label)	_____
_____	Date **Originally** Prescribed	_____
_____	Frequency and Dosage	_____
	Diagnosis/Condition	
_____	Medication Name (copy off pharmacy label)	_____
_____	Date **Originally** Prescribed	_____
_____	Frequency and Dosage	_____
	Diagnosis/Condition	

6. HOUSEHOLD DISCOUNT INFORMATION – Please Answer BOTH Questions 1 & 2 In This Section.

You may be eligible for a policy with a lower rate based on your answers to the statements in this section.	**Applicant**	**Applicant B**
1. I have continuously resided with another person for the last 12 months or are married and they are also applying for this coverage. If "YES," please complete the information regarding Relationship to Applicant below, unless you AND Applicant B are applying for coverage on THIS application then do not complete the Relationship to Applicant information.	Yes ☐ No ☐	Yes ☐ No ☐
2. I have continuously resided with another person for the last 12 months or are married and they have an existing Medicare supplement policy or certificate with Mutual of Omaha Insurance Company or United World Life Insurance Company or United of Omaha Life Insurance Company. If you answer "YES," to this question, please complete the information regarding Relationship to Applicant below.	Yes ☐ No ☐	

Relationship to Applicant:

First Name

Last Name

Street Address

City State ZIP

Policy/Certificate Number

7. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

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

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

Premium Must Accompany Application

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

_____ _____
(Signature of Licensed Producer) (Signature of Licensed Producer)

_____ _____
PRODUCER STAMP PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 Question #15 or PART 5 Question #5 - CON'T. HEALTH /MEDICAL QUESTIONS		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan _____

Before you begin: *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

Line	Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
#1	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided.	$128.52		
#2	**Household Discount** Are you eligible to receive a household discount? If yes, multiply line #1 by .93. If no, enter the amount from line #1.	$128.52 x .93 = $119.52 In this example, the person qualifies for the household discount.		
#3	**Rate Adjustment** *If you're in your open enrollment or guarantee issue period, skip to step #4.* On page 2, locate your height, then weight. If your weight is in the Standard column, enter the amount from line #2. If your weight is in the Class I or II column, multiply the amount on line #2 by: 1.10 if in 10% column 1.20 if in 20% column	$119.52 x 1.20 = $143.42 Person's weight is in the Class II 20% column.		
#4	**Payment Options** Your monthly payment is your last premium entered (line #2 or #3). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$143.42 monthly payment $430.26 quarterly payment $860.52 semiannual payment $1,721.04 annual payment		

Complete and return with application

Height and Weight Chart

Eligibility

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

Rate Adjustment

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

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	‹ 54	54 – 60	61 – 110	111 – 128	129 – 145	146 +
4' 3''	‹ 56	56 – 62	63 – 114	115 – 133	134 – 151	152 +
4' 4''	‹ 58	58 – 65	66 – 119	120 – 138	139 – 157	158 +
4' 5''	‹ 60	60 – 67	68 – 123	124 – 143	144 – 163	164 +
4' 6''	‹ 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7''	‹ 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8''	‹ 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9''	‹ 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4' 10''	‹ 72	72 – 81	82 – 148	149 – 172	173 – 196	197 +
4' 11''	‹ 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0''	‹ 77	77 – 87	88 – 158	159 – 184	185 – 209	210 +
5' 1''	‹ 80	80 – 89	90 – 164	165 – 190	191 – 216	217 +
5' 2''	‹ 83	83 – 92	93 – 169	170 – 196	197 – 224	225 +
5' 3''	‹ 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5' 4''	‹ 88	88 – 99	100 – 180	181 – 209	210 – 238	239 +
5' 5''	‹ 91	91 – 102	103 – 186	187 – 216	217 – 246	247 +
5' 6''	‹ 93	93 – 105	106 – 192	193 – 223	224 – 254	255 +
5' 7''	‹ 96	96 – 108	109 – 197	198 – 229	230 – 261	262 +
5' 8''	‹ 99	99 – 111	112 – 203	204 – 236	237 – 269	270 +
5' 9''	‹ 102	102 – 115	116 – 209	210 – 243	244 – 277	278 +
5' 10''	‹ 105	105 – 118	119 – 216	217 – 250	251 – 285	286 +
5' 11''	‹ 108	108 – 121	122 – 222	223 – 258	259 – 293	294 +
6' 0''	‹ 111	111 – 125	126 – 228	229 – 265	266 – 302	303 +
6' 1''	‹ 114	114 – 128	129 – 234	235 – 272	273 – 310	311 +
6' 2''	‹ 117	117 – 132	133 – 241	242 – 280	281 – 319	320 +
6' 3''	‹ 121	121 – 136	137 – 248	249 – 288	289 – 328	329 +
6' 4''	‹ 124	124 – 139	140 – 254	255 – 295	296 – 336	337 +
6' 5''	‹ 127	127 – 143	144 – 261	262 – 303	304 – 345	346 +
6' 6''	‹ 130	130 – 147	148 – 268	269 – 311	312 – 354	355 +
6' 7''	‹ 134	134 – 150	151 – 275	276 – 319	320 – 363	364 +
6' 8''	‹ 137	137 – 154	155 – 282	283 – 327	328 – 373	374 +
6' 9''	‹ 140	140 – 158	159 – 289	290 – 335	336 – 382	383 +
6' 10''	‹ 144	144 – 162	163 – 296	297 – 344	345 – 392	393 +
6' 11''	‹ 147	147 – 166	167 – 303	304 – 352	353 – 401	402 +
7' 0''	‹ 151	151 – 170	171 – 311	312 – 361	362 – 411	412 +
7' 1''	‹ 155	155 – 174	175 – 318	319 – 369	370 – 421	422 +
7' 2''	‹ 158	158 – 178	179 – 326	327 – 378	379 – 431	432 +
7' 3''	‹ 162	162 – 183	184 – 333	334 – 387	388 – 441	442 +
7' 4''	‹ 166	166 – 187	188 – 341	342 – 396	397 – 451	452 +

Medicare supplement insurance is underwritten by
United of Omaha Life Insurance Company
A Mutual *of* Omaha Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
mutualofomaha.com

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Policy Delivery

Mail policy/policies to:

a) Applicant ☐ Producer ☐

b) Applicant B ☐ Producer ☐

Producer(s) Information

Producer Name Ryan Kennelly Social Security No _____

Comm. % Share _____ Producer Phone No (630) 9309364 Commission Code 0513797

Producer E-mail Address ryan @ ilhealthagents.com

Producer FAX Number 847.220.9280

Producer Name _____ Social Security No _____

Comm. % Share _____ Producer Phone No (___) _____ Commission Code _____

Producer E-mail Address _____ @ _____

Producer FAX Number _____

(Note: Producers must be under the same commission code to share or split commissions.)

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

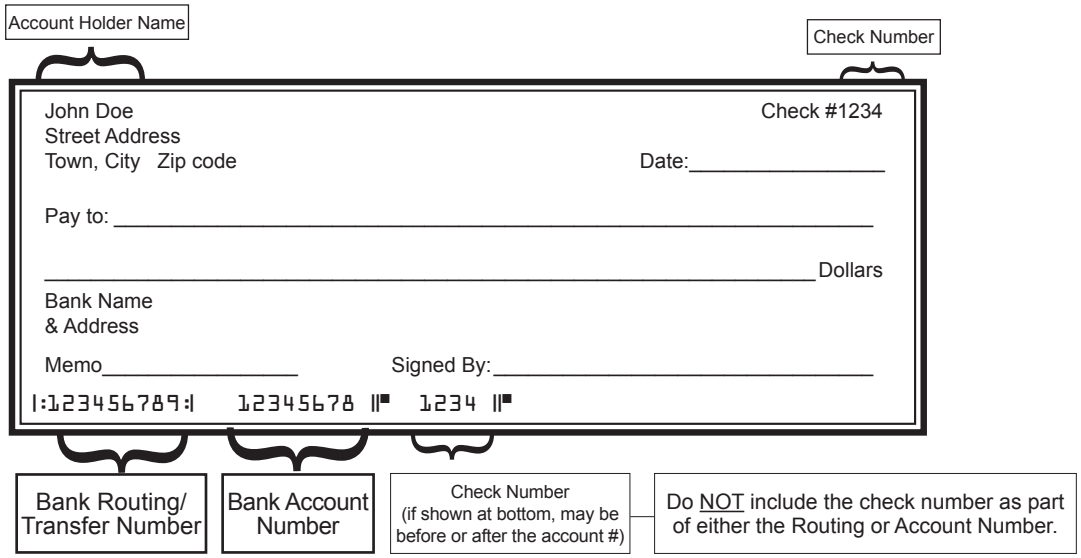
If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Instructions for Completion of Authorization for Electronic Funds Transfer (ACH/BSP) Form



The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).
Automated Clearing House (ACH) is used for initial payment and **Bank Service Plan** (BSP) is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. DO NOT submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP
When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)
When choosing to pay the initial premiums by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), the applicant must complete the form and submit it with the application. DO NOT submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premiums by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer form so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Please refer to instructions on the Front of this form.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

Medicare Supplement Premium Payment Options:	**Applicant A** YES	**Applicant A** NO	**Applicant B** YES	**Applicant B** NO
A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (**ACH** is used for initial payment and **BSP** is used for renewal payments.)	☐	☐	☐	☐
B. Pay 1st premium by signed paper check and pay monthly renewals by BSP	☐	☐	☐	☐
C. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)**	☐	☐	☐	☐
• If choosing Options A or C, list amount of initial premium withdrawal	$ _____		$ _____	
• If choosing Options A or B, select a withdrawal date for monthly renewal payments (circle one)	☐ 1st or 15th	☐	☐ 1st or 15th	☐
• Is a Business Account being used to pay premiums?	☐	☐	☐	☐
• If yes, is the applicant:				
(a) Unemployed	☐	☐	☐	☐
(b) Employed, but not working for the business that is paying the premium	☐	☐	☐	☐
(c) The business owner or spouse of the business owner	☐	☐	☐	☐

If (A), (B), or (C) are "Yes," premiums CAN be paid with a business account.

Applicant A | **Applicant B**

Complete the information below. To avoid potential delays in processing, submit a copy of a voided check.

Account Type (check one): ☐Checking ☐Savings

_____
Name of Financial Institution

_____
Routing Number (first 9 digits on lower left side of check)

_____
Account Number
(Do NOT use Debit or Credit Card account numbers)

_____
Name as Shown on Account

Account Type (check one): ☐Checking ☐Savings

_____
Name of Financial Institution

_____
Routing Number (first 9 digits on the lower left side of check)

_____
Account Number
(Do NOT use Debit or Credit Card account numbers)

_____
Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize United of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to United of Omaha. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three-business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

_____
Authorized Signature as Shown on Account

_____
Date

_____
Authorized Signature as Shown on Account

_____
Date

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

PLEASE SIGN AND RETURN THIS AUTHORIZATION WITH YOUR COMPLETED APPLICATION

Authorization To Disclose Personal Information To United of Omaha Life 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. 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 to United of Omaha Life Insurance Company.

Purposes

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.

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
United of Omaha Life 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 United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life 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.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Names and Signatures

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

_____

Applicant	**Applicant B**
Printed Name of Proposed Applicant	Printed Name of Proposed Applicant
Signature of Proposed Applicant	Signature of Proposed Applicant
Date	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Medicare Supplement Checklist—ILLINOIS

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient	First 60 days	All but $1,132.00		UM20 – Nothing UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – $1,132.00 (Part A Deductible)	UM20 – $1,132.00 (Part A Deductible) UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – Nothing
	61st through 90th day	All but $283.00 a day		UM20, UM23, UM24, UM30, UM31- $283.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $566.00 a day		UM20, UM23, UM24, UM30, UM31 - $566.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	Beyond 150 days	Nothing		UM20, UM23, UM24, UM30, UM31 - 100% of Medicare eligible expenses	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
Skilled Nursing Home Care	First 20 days	100% of approved amounts		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - Nothing
	21st through 100th days	All but $141.50 a day		UM20 – Nothing UM23, UM24, UM30, UM31 – Up to $141.50 a day	UM20 – Up to $141.50 a day UM23, UM24, UM30, UM31 – Nothing
	101st day and after	Nothing		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - All costs
Medical Expenses	In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	Nothing		UM20, UM24, UM30, UM31 – Nothing UM23 – $162.00 (Part B Deductible)	UM20, UM24, UM30, UM31 – $162.00 (Part B Deductible) UM23 – Nothing
	Remainder of Medicare approved amounts	Generally 80%		UM20, UM23, UM24, UM30 - Generally 20% UM31- Balance, other than copayment	UM20, UM23, UM24, UM30 - Nothing UM31-$20 per office visit and $50 per emergency room visit
	Part B excess charges (above Medicare approved amounts)	Nothing		UM20, UM30, UM31 – Nothing UM23 – 100% UM24 – 100%	UM20, UM30, UM31 – 100% UM23 – Nothing UM24 – Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date _____ Signature of Applicant _____

Signature of Agent/Insurance Producer Ryan Kennelly _____

Digitally signed by Ryan Kennelly
DN: cn=Ryan Kennelly, o=Illinois Health Agents, ou, email=ryan@ihealthagents.com, c=US
Date: 2011.05.24 10:04:20 -05'00'

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Medicare Supplement Checklist—ILLINOIS

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient	First 60 days	All but $1,132.00		UM20 – Nothing UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – $1,132.00 (Part A Deductible)	UM20 – $1,132.00 (Part A Deductible) UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – Nothing
	61st through 90th day	All but $283.00 a day		UM20, UM23, UM24, UM30, UM31- $283.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $566.00 a day		UM20, UM23, UM24, UM30, UM31 - $566.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	Beyond 150 days	Nothing		UM20, UM23, UM24, UM30, UM31 - 100% of Medicare eligible expenses	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
Skilled Nursing Home Care	First 20 days	100% of approved amounts		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - Nothing
	21st through 100th days	All but $141.50 a day		UM20 – Nothing UM23, UM24, UM30, UM31 – Up to $141.50 a day	UM20 – Up to $141.50 a day UM23, UM24, UM30, UM31 – Nothing
	101st day and after	Nothing		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - All costs
Medical Expenses	In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	Nothing		UM20, UM24, UM30, UM31 – Nothing UM23 – $162.00 (Part B Deductible)	UM20, UM24, UM30, UM31 – $162.00 (Part B Deductible) UM23 – Nothing
	Remainder of Medicare approved amounts	Generally 80%		UM20, UM23, UM24, UM30 - Generally 20% UM31- Balance, other than copayment	UM20, UM23, UM24, UM30 - Nothing UM31-$20 per office visit and $50 per emergency room visit
	Part B excess charges (above Medicare approved amounts)	Nothing		UM20, UM30, UM31 – Nothing UM23 – 100% UM24 – 100%	UM20, UM30, UM31 – 100% UM23 – Nothing UM24 – Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date _____ Signature of Applicant _____

Signature of Agent/Insurance Producer _____

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

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

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 or certificate.

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 or certificate 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 or certificate is being purchased for the following reason(s) (check one):

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

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.
2. Section 363(7)(b) of the Illinois Insurance Code provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent under the original policy or certificate.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy or certificate 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 or certificate and are sure that you want to keep it.

✗ _____

Signature of Agent, Broker or Other Representative*

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

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales

IMPORTANT DOCUMENTS

CLIENT FORMS

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 if applicable.

Replacement Notice (If replacing, both you and the applicant must sign the customer copy of the replacement notice)

Medicare Supplement Checklist

Conditional Receipt / Notice of Information Practices

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

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

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 or certificate.

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 or certificate 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 or certificate is being purchased for the following reason(s) (check one):

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

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.
2. Section 363(7)(b) of the Illinois Insurance Code provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent under the original policy or certificate.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy or certificate 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 or certificate and are sure that you want to keep it.

✗ Ryan Kennelly

Digitally signed by Ryan Kennelly
DN: cn=Ryan Kennelly, o=Illinois Health Agents, ou, email=ryan@ilhealthagents.com, c=US
Date: 2011.05.24 10:09:23 -05'00'

Signature of Agent, Broker or Other Representative*

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

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Medicare Supplement Checklist—ILLINOIS

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient	First 60 days	All but $1,132.00		UM20 – Nothing UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – $1,132.00 (Part A Deductible)	UM20 – $1,132.00 (Part A Deductible) UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – Nothing
	61st through 90th day	All but $283.00 a day		UM20, UM23, UM24, UM30, UM31- $283.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $566.00 a day		UM20, UM23, UM24, UM30, UM31 - $566.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	Beyond 150 days	Nothing		UM20, UM23, UM24, UM30, UM31 - 100% of Medicare eligible expenses	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
Skilled Nursing Home Care	First 20 days	100% of approved amounts		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - Nothing
	21st through 100th days	All but $141.50 a day		UM20 – Nothing UM23, UM24, UM30, UM31 – Up to $141.50 a day	UM20 – Up to $141.50 a day UM23, UM24, UM30, UM31 – Nothing
	101st day and after	Nothing		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - All costs
Medical Expenses	In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	Nothing		UM20, UM24, UM30, UM31 – Nothing UM23 – $162.00 (Part B Deductible)	UM20, UM24, UM30, UM31 – $162.00 (Part B Deductible) UM23 – Nothing
	Remainder of Medicare approved amounts	Generally 80%		UM20, UM23, UM24, UM30 - Generally 20% UM31- Balance, other than copayment	UM20, UM23, UM24, UM30 - Nothing UM31-$20 per office visit and $50 per emergency room visit
	Part B excess charges (above Medicare approved amounts)	Nothing		UM20, UM30, UM31 – Nothing UM23 – 100% UM24 – 100%	UM20, UM30, UM31 – 100% UM23 – Nothing UM24 – Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date _____ Signature of Applicant _____

Signature of Agent/Insurance Producer Ryan Kennelly Digitally signed by Ryan Kennelly DN: cn=Ryan Kennelly, o=Illinois Health Agents, ou, email=ryan@ihealthagents.com, c=US Date: 2011.05.24 10:08:23 -05'00' _____

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Medicare Supplement Checklist—ILLINOIS

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient	First 60 days	All but $1,132.00		UM20 – Nothing UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – $1,132.00 (Part A Deductible)	UM20 – $1,132.00 (Part A Deductible) UM30 – $566.00 (50% of Part A deductible) UM23, UM24, UM31 – Nothing
	61st through 90th day	All but $283.00 a day		UM20, UM23, UM24, UM30, UM31- $283.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $566.00 a day		UM20, UM23, UM24, UM30, UM31 - $566.00 a day	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
	Beyond 150 days	Nothing		UM20, UM23, UM24, UM30, UM31 - 100% of Medicare eligible expenses	UM20, UM23, UM24, UM30, UM31 - Nothing for covered expenses
Skilled Nursing Home Care	First 20 days	100% of approved amounts		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - Nothing
	21st through 100th days	All but $141.50 a day		UM20 – Nothing UM23, UM24, UM30, UM31 – Up to $141.50 a day	UM20 – Up to $141.50 a day UM23, UM24, UM30, UM31 – Nothing
	101st day and after	Nothing		UM20, UM23, UM24, UM30, UM31 - Nothing	UM20, UM23, UM24, UM30, UM31 - All costs
Medical Expenses	In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	Nothing		UM20, UM24, UM30, UM31 – Nothing UM23 – $162.00 (Part B Deductible)	UM20, UM24, UM30, UM31 – $162.00 (Part B Deductible) UM23 – Nothing
	Remainder of Medicare approved amounts	Generally 80%		UM20, UM23, UM24, UM30 - Generally 20% UM31- Balance, other than copayment	UM20, UM23, UM24, UM30 - Nothing UM31-$20 per office visit and $50 per emergency room visit
	Part B excess charges (above Medicare approved amounts)	Nothing		UM20, UM30, UM31 – Nothing UM23 – 100% UM24 – 100%	UM20, UM30, UM31 – 100% UM23 – Nothing UM24 – Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date _____ Signature of Applicant _____

Ryan Kennelly Digitally signed by Ryan Kennelly DN: cn=Ryan Kennelly, o=Illinois Health Agents, ou, email=ryan@ihealthagents.com, c=US Date: 2011.05.24 10:09:01 -05'00'

Signature of Agent/Insurance Producer _____

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Conditional Receipt

Check or Money Order Application

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

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

Applicant

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

Applicant B

Received of _____

this _____ day of

_____, _____

an application for Form _____ Policy

and/or Riders _____ and

Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

NOTICE TO APPLICANT: Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.

Complete Receipt in full and leave with applicant at time of application.

United of Omaha Life 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: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Give this notice to the applicant.