

Application Instructions for Mutual of Omaha Illinois Medicare Supplement Plan

- 1. Have your Medicare card and Social Security card available to fill in the required information below.
- 2. Fill out all pages of the application, including policy checklist. If you are not replacing a Medicare supplement or Medicare Advantage Plan, disregard the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."
- 3. Complete all questions and sections of the application. Mail to the address below or complete the fax cover letter below and fax to (847) 220-9280 for review along with the completed application and policy checklist.
- 4. SEND NO MONEY NOW! No payment is due until you have a chance to review your policy.

1. Mail the Completed Policy to:

Illinois Health Agents Attn: Medicare Enrollment 75 Forest Ave Glen Ellyn, IL 60137

OR

2. Fax Using the Enclosed Fax Cover Letter:

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

FAX#: 847-220-9280

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name	-
E-mail	_
Date	
Time	

We will review your application for completeness and accuracy before it is submitted for processing.

Please contact us if you have any questions regarding the application or the application process. You can reach us at (630) 930-9364.

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code- Required <u>on</u> you are not appointed or licens are changing brokerage firms
ת			%
-1			%
Drafarrad Mathad of Communicativ	[Soloct one]		
Preferred Method of Communication Provide Text Provident C Provide Text Provident C Provide Text Provided Text Pro	ontact info:		
	me commission code to share or split co	mmissions. Please	update your contact
information at <u>http://www.mutu</u>			
Application Submission (<u> Checklist – Mutual of Omah</u>	<u>a Medicare S</u>	upplement Coverage
Provide Applicant with the	Guide to Health Insurance for Pe	ople with Medica	are
Provide Applicant with the	Outline of Coverage	-	
 Calculate the premium Tobasso rates do not a 	based on age at application date pply during open enrollment or gu	iarantood issue	situations
_	ur Premium form (M28043) to det		Situations
Application (complete in fi	• •	ennine rate	
Sections A & B: Plan and			
 Select plan 			
 Enter Requested Effect Indicate where the policity 	ive Date		
Section C: Medicare Inforr	-		
 Include applicant's Med 	dicare claim number on the application	ation. This numbe	er is required for electron
claim processing. If this	s number is not available at time o	t application, the	applicant/agent must
Medicare, indicate "eliş	s number is not available at time o calling 1-877-617-5587 once it is gibility" and "enrollment" dates.	Teceiveu. II not a	diready covered by
Section D: Household Prei	mium Discount Information Household Premium Discount		
0	sting Coverage Information		
	Open Enrollment/Guaranteed Issue w	vorksheet (M2778	8) to help identify eligibilit
Section F: Please answer	all of the following questions		
 If either Applicant A or 	B answered "YES" to question 7 (<u> DR BOTH</u> questio	ns 8 and 9 in Section F,
they can skip to Sectio Sections G & H: Health/M			
	cant is in an open enrollment or gua	aranteed issue pe	riod
Section I: Agreement and	Authorization		
	sign and date the application		
Section K: To be Complete	ed by Producer sign and date the application		
	ayment form (M27784) and return	with the compl	eted application
 Úse premium determin 	n is collected at the time of applic	n form (M28043)	
	tice (M18362-11_0605) and leav		e applicant (if applicable
	emium Receipt signed by agent (if		
	plement Checklist (M27975_IL) a	nd leave a copy w	vith the applicant.
	$a_{\text{varify}}/confirm the information varies of the information of t$		

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

Open Enrollment and Guaranteed Issue Worksheet

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

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ¹/₂ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

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

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations. Applicant:



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

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

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

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

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

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

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

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

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

Acceptable Evidence of Eligibility:

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

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan

Applicant A _____



Applicant B

Before you begin: Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	Age Write in your age at the time of signing the application. ZIP Code	65		
	Indicate your ZIP Code used to determine your rate.	51502		
#2	Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	Household Premium Discount Does a member of your household:	\$128.52 x .93 = \$119.52		
	 (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married 	In this example, the person qualifies for the household		
	either have an existing Medicare supplement plan with, or are applying for coverage with, Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?	premium discount.		
	If yes, multiply the amount from Step #2 by .93. If no, enter the amount from Step #2.			
#4	Rate Adjustment If you're in your open enrollment or guaranteed issue period, skip to Step #5.	\$119.52 x 1.20 = \$143.42		
	Locate your height, then weight on the next page.			
	 If your weight is in the Standard column, enter the amount from Step #3 If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 20 if in Class II column 	Person's weight is in the Class II column.		
#5	Payment Options Your monthly payment is your last premium entered (Step #3 or #4).	\$143.42 monthly payment		
	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)	\$430.26 quarterly payment \$860.52 semiannual payment \$1,721.04 annual payment		

Height and Weight Chart

Eligibility

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

Rate Adjustment

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

	Decline	Class I	Standard	Class I	Class II	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	< 54	54 - 60	61 - 110	111 – 128	129 – 145	146 +
4' 3''	< 56	56 - 62	63 - 114	115 – 133	134 – 151	152 +
4' 4''	< 58	58 - 65	66 - 119	120 - 138	139 – 157	158 +
4' 5''	< 60	60 - 67	68 - 123	124 – 143	144 – 163	164 +
4' 6''	< 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7''	< 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8''	< 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9''	< 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4'10''	< 72	72 - 81	82 - 148	149 – 172	173 – 196	197 +
4'11''	< 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0''	< 77	77 – 87	88 - 158	159 – 184	185 – 209	210 +
5' 1''	< 80	80 - 89	90 - 164	165 – 190	191 – 216	217 +
5' 2''	< 83	83 – 92	93 - 169	170 – 196	197 – 224	225 +
5' 3''	< 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5'4''	< 88	88 – 99	100 - 180	181 – 209	210 – 238	239 +
5' 5''	< 91	91 - 102	103 - 186	187 – 216	217 – 246	247 +
5' 6''	< 93	93 – 105	106 – 192	193 – 223	224 - 254	255 +
5' 7''	٧ 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 MUTUAL *of* OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza Omaha, Nebraska 68175 *mutualofomaha.com*



FAV Key_

Group # (if applicable)

Auth # Keyline

Антиаг¢Отана

MUTUAL of OMAHA INSURANCE COMPANY

Application for Medicare Supplement Coverage

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

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B	
Plan (select one) Plan A Plan F Plan G	Plan (select one) Plan A Plan F Plan G	
Requested Effective Date /	Requested Effective Date /	
	Deliver Policy to Applicant B Producer	

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State 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 Area code)	Home Phone Area code)
E-mail Address	E-mail Address
Current Age	Current Age
Date of Birth mo / day / yr	Date of Birth / / / yr
Male Female	Male Female
Social Security #	Social Security #
Height Weight Ft In Lbs	Height Weight Ft In Lbs
MA5985-11 MUTUAL of OMAHA INSURANCE COMPANY	• P.O. Box 3608 • Omaha, Nebraska 68103-3608 1

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B. Applicant Information (continued)

Applicant A	Applicant B			
Have you used tobacco in any form in the past 12 months? Y N	Have you used tobacco in any form in the past 12 months? Y			
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will <u>not</u> receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Mutual of Omaha.				
Receive statement online? \Box Y \Box N	Receive statement online?			

C. Medicare Information

Please reference your Medicare card to complete this section	JANE DOE MEDICARE CLAIM NUMBER 000-00-0000-A IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B) SEX FEMALE 07-01-2010 07-01-2010
Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date ////////////////////////////////////	Medicare Part A Effective Date ////////////////////////////////////
Medicare Part B Effective Date//// If you are not covered under Medicare Part B, indicate the date you plan to enroll	Medicare Part B Effective Date ////////////////////////////////////

D. Household Premium Discount Information

	You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	Applicant A	Applicant B
1	 Does a member of your household: (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married or in a civil union partnership either have an existing Medicare supplement plan with, or are applying for coverage with United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?	□ y □ N	□ y □ N
5-11	if both applicants are both applying for coverage on this application.		
MA5985	Name (First/Middle/Last)		
MA	Policy Number		
	Street Address		
	City/State/ZIP		



E. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.				
3. Aı (N nd	e Best of Your Knowledge and Belief: re you covered for medical assistance through the state M IOTE TO APPLICANT: If you are participating in a "Spend-D ot met your "Share of Cost," please answer "NO" to this qu	own Program" and have uestion.)	Applicant A Applicant B Y N Y N	
(a (b	 "YES," answer the following about this existing coverage Will Medicaid pay your premiums for this Medicare sup Do you receive any benefits from Medicaid OTHER THAN Medicare Part B premium? 	plement policy? I payments toward your		
Pleas	e answer questions regarding another Medicare sup	plement or Select plan:		
ce If	o you have another Medicare supplement or Medicare Sel ertificate in force?	:		
(a) Do you intend to replace your current Medicare supplemen with this policy?			
(b) Indicate planned termination or disenrollment date	Applicant A		
(c) With what company, and what plan do you have?	Applicant B		
	cant A	Applicant D		
		Applicant B		
	e of Company	Name of Company		
Plan Plan				
Pleas	se answer questions regarding Medicare plan covera		ıpplement):	
5. Ha	se answer questions regarding Medicare plan covera ave you had coverage from any Medicare plan other than M ast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existin	ge (other than Medicare su ledicare Part A or B within the Medicare HMO or PPO)	Applicant A Applicant B Y N Y N	
5. Ha pa lf	ave you had coverage from any Medicare plan other than N ast 63 days? (for example, a Medicare Advantage plan, or a	ge (other than Medicare su ledicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan,	Applicant A Applicant B	
5. Ha pa lf	ave you had coverage from any Medicare plan other than M ast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existi) Fill in your start and end dates below. If you are still cove	ge (other than Medicare su ledicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan,	Applicant A Applicant B	
5. Ha pa lf	ave you had coverage from any Medicare plan other than M ast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existi) Fill in your start and end dates below. If you are still cove	ge (other than Medicare su Nedicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan, Applicant A START	Applicant A Applicant B	
5. Ha pa lf	ave you had coverage from any Medicare plan other than M ast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existi) Fill in your start and end dates below. If you are still cove	ge (other than Medicare su Nedicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan, Applicant A START END	Applicant A Applicant B	
5. Ha pa If (a	ave you had coverage from any Medicare plan other than M ast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existi) Fill in your start and end dates below. If you are still cove	ge (other than Medicare su Nedicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan, Applicant A START END Applicant B START END	Applicant A Applicant B	
5. Ha pa If (a	 ave you had coverage from any Medicare plan other than Mast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existin) Fill in your start and end dates below. If you are still coverage "END" blank If you are still covered under the Medicare plan, do you i coverage with this new Medicare supplement policy? 	ge (other than Medicare su Nedicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan, Applicant A START END Applicant B START END ntend to replace your current	Applicant A Applicant B Y N Y N	
5. Ha pa If (a (b)	 ave you had coverage from any Medicare plan other than Mast 63 days? (for example, a Medicare Advantage plan, or a "YES," answer the following about this previous or existing) Fill in your start and end dates below. If you are still cover leave "END" blank If you are still covered under the Medicare plan, do you i coverage with this new Medicare supplement policy? Planned date of termination/disenrollment? Was this your first time in this type of Medicare plan? 	ge (other than Medicare su Medicare Part A or B within the Medicare HMO or PPO) ng coverage: ered under this plan, Applicant A START END Applicant B START END ntend to replace your current Applicant A Applicant B Applicant B	Applicant A Applicant B Y N Y N	

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 (g) Please indicate reason for termination/disenrollment: Your Medicare Advantage plan is leaving the Medicare program Your Medicare Advantage organization stopped offering Medicare Advantage plan Your Medicare Advantage organization stopped offering coverage in the area in which you live You moved out of the geographic service area of your Medicare Advantage plan You had a Medicare Advantage plan with Medicare Part D benefits and are enroll in a stand-alone Medicare Part D plan Other: Applicant A Applicant B 	s
Please answer questions regarding other health insurance:	
 6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer group health plan, union plan, or individual non-Medica supplement plan.) If "YES," answer the following about this previous or existing coverage: (a) What are your dates of coverage under the other policy/certificate? 	
If you are still covered under this plan, leave "END" blank Applicant A	
Applicant B	END/// START/// END///
(b) Planned date of termination/disenrollment?	cant A
Appli	cant B
(c) Have you disenrolled from your current coverage voluntarily?	🗆 Y 🗋 N 🗋 Y 🗋 N
Applicant A	
Applicant B (e) With what company and what kind of policy/certificate? (List below.)	
Applicant A Applicant B	
Name of Company Name of Company	
Policy/Certificate type Policy/Certificate type	

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
 7. Are you applying during a guaranteed issue period?		
If "YES," indicate your effective date Applicant A Applicant B		

STOP

IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO <u>QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN</u> <u>SECTION F</u>, SKIP SECTIONS G & H AND GO TO SECTION I.

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

G. Health Information

For all plans, answer questions 10-21.

(If "YES" is answered to any of the following questions 10-20, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?	Ξ́Υ 🗆 Ν	ĹΥΩΝ
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?		
12. Are you currently receiving any occupational or physical therapy?		
13. Have you been advised by a medical professional to have treatment, further diagnostic		
evaluation, diagnostic testing or any surgery that has not been performed? 14. At any time have you been medically diagnosed with, treated for, or had surgery for any of	□ y □ N	
the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	Π Υ Π Ν	□ y □ n
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?		
C. Alzheimer's Disease, dementia or any other cognitive disorder?	□ y □ n	
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?		
E. Systemic Lupus or Myasthenia Gravis?		
F. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?		
G. Chronic hepatitis or cirrhosis?		
H. Osteoporosis with fractures?15. At any time have you been medically diagnosed with, treated or tested for Acquired	□ y □ N	
Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a physician or an appropriately licensed clinical professional acting within the scope of his/her license?	□ y □ n	
16. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?		
17. Do you have an implanted cardiac defibrillator?		
18. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?		
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral		
vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart		
or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?		
C. Alcoholism or drug abuse?		
D. Any mental or nervous disorder requiring treatment (including hospital confinement)		
by a psychiatrist, psychologist, counselor or therapist?	□ y □ n	
E. Internal cancer, lymphoma or melanoma?	□ y □ N	□ y □ n
F. A stroke or transient ischemic attack (TIA)?	Π Y Π N	□ y □ n
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	Π Υ Π Ν	
19. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	□ y □ n	□ y □ n
20. Have you been hospital confined three or more times in the past two years for a same or similar condition?	□ y □ n	
21. Have you taken any prescription drugs in the past 24 months?		
(If YES, please complete the Medication Information sheet on the next page)	LIY LI N	



H. Medication Information

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

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Y N	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Y N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			Y N	Ωy Ωn	
			Y N	Y N	
			Ωy Ωn	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			□y □n	Ωy Ωn	
			□y □n	Ωy Ωn	
			Ωy Ωn	Ωy Ωn	
			□y □n	Ωy Ωn	
			□y □n	Ωy Ωn	

I. Agreement and Authorization

IMPORTANT STATEMENTS

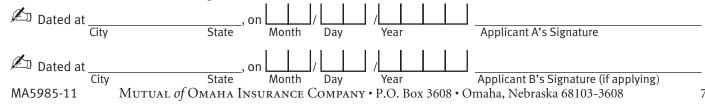
- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO MUTUAL OF OMAHA INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Mutual of Omaha. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha has taken action in reliance on the authorization or the law allows Mutual of Omaha to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

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

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





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

K. To be Completed by Producer

- 22. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).
- (a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A

Applicant B

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

Applicant A

Applicant B

I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant(s)	ΠY] N
I/We certify that we have interviewed the proposed applicant(s)	ΠY	N

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

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

Signature of Licensed Producer	Date	Signature of Licensed Producer	Date
Printed Name		Printed Name	
0 5 1 3 7 9 7			
Agent Writing Number		Agent Writing Number	

MA5985-11

Митиаl of Омана Insurance Сомрану • Р.О. Box 3608 • Omaha, Nebraska 68103-3608

METHOD OF PAYMENT FORM Part I. Select Premium Payment Option

REQUIRED FORM – PLEASE RETURN

Initial Premium (Select option #1 <u>or</u> #2)	Applicant A	Applicant B		
Initial premium amount (based on age at application date)	\$	\$ 1 1 1 1 1 1 1		
2. Automated Bank Account Withdrawal				
Ongoing Premium Payments (Select option #1 or #2)				
 I want my payments automatically withdrawn from my bank account every month on (Circle date) 	1 st or 15 th	1 st or 15 th		
 I will mail my premium to the company every 3, 6, or 12 months. 				
(Monthly billing is not allowed. Select frequency of billing)	everymonths Insert 3, 6, or 12	everymonths		
Part II. Payor Information	msett 9, 0, 01 12	insert 5, 0, 01 12		
Complete the following if premium is NOT paid by applicant	Applicant A	Applicant B		
(includes spouse or joint-married account):				
1. Account Owner Name, if different than applicant's				
2. Account Owner Relationship to applicant: Employer				
Living Trust				
Power of Attorney or legal guardian (documentation required)				
Business owned by applicant or applicant's spouse				
Part III. Account Information	drowel is Chasen.			
Complete the Following ONLY if <u>Automated Bank Account With</u> This section is intended as authorization to debit your bank accou Complete bank account information below OR attach a copy of a v	int.			
Applicant A Account Type (check one): Checking Savings		ount as Applicant A		
Applicant A Account Type (check one): Checking Savings Name of Financial Institution Image: Applicant A Image: Applicant A Routing Number (9 digits on lower left side of check) Account Number (Do NOT use Debit/Credit Card numbers)	Account Type (check one):	Checking Savings		
Name of Financial Institution	Name of Financial Institution			
Routing Number (9 digits on lower left side of check)	Routing Number (9 digits on lo	wer left side of check)		
Š				
G				
Account Number (Do NOT use Debit/Credit Card numbers)	Account Number (Do NOT use De	ebit/Credit Card numbers)		
	Name of Chaum on Assount			
	Name as Shown on Account	Do NOT include the check # in the		
 Payments cannot be postponed until a later date. Payment from a third party, including any foundation, will 	Account Holder Name	Routing or Account Number.		
not be accepted, except in certain pre-approved situations.	Street Address	Check #1234		
 All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc. 	Town, City ZIP Code Pay to:	Date:		
	Number Financial Institution	AccountDollars Number		
	Name & Address			
		345678 1234		
IMPORTANT: When choosing to pay initial premium by Automated Ba	nk Account Withdrawal, MONEY	WILL BE WITHDRAWN FROM		
YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be differed I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha	a") to withdraw funds from my a	ccount for my initial and/		
or monthly renewal premiums and understand that the amounts may causes, including underwriting adjustments. I authorize you, my fina	/ differ. Premium shortages may	v result from a variety of		
Omaha any preauthorized electronic fund transfers. Your rights with o	each charge will be the same as	s if personally paid by me.		
Omaha any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.				
	Authorized Signature as Shown of	on Account		
Date	Date			



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 Mutual of Omaha 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.
- Section 363(7)(b) of the Illinois Insurance Code provides that your replacement policy or certificate may not contain new 2. 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.

	Æn	
	Signature of Agent, Broker or Other Representative	* Date
0605	Mutual of Omaha Insurance Company, Mutual of Omaha	Plaza, Omaha, NE 68175
\leftarrow	Applicant	Applicant B
362-1	Signature	Signature
83(
M18	Date	Date

*Signature not required for direct response sales

Medicare Supplement Checklist—ILLINOIS

Please complete the following fields and the "Existing Coverage" column with the applicant's existing coverage information.

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 \$1,156.00		Plan A – Nothing Plan M – \$578.00 (50% of Part A deductible) Plans F, G – \$1,156.00(Part A Deductible)	Plan A – \$1,156.00 (Part A Deductible) Plan M – \$578.00 (50% of Part A deductible) Plans F, G, – Nothing
	61st through 90th day	All but \$289.00 a day		Plans A, F, G, M - \$289.00 a day	Plans A, F, G, M - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but \$578.00 a day		Plans A, F, G, M - \$578.00 a day	Plans A, F, G, M - Nothing for covered expenses
	Beyond 150 days	Nothing		Plans A, F, G, M - 100% of Medicare eligible expenses	Plans A, F, G, M - Nothing for covered expenses
Skilled Nursing Home Care	First 20 days	100% of approved amounts		Plans A, F, G, M - Nothing	Plans A, F, G, M - Nothing
	21st through 100th days	All but \$144.50 a day		Plan A – Nothing Plans F, G, M – Up to \$144.50 a day	Plan A – Up to \$144.50 a day Plans F, G, M – Nothing
	101 st day and after	Nothing		Plans A, F, G, M - Nothing	Plans A, F, G, M - 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		Plans A, G, M – Nothing Plan F – \$140.00 (Part B Deductible)	Plans A, G, M – \$140.00 (Part B Deductible) Plan F – Nothing
	Remainder of Medicare approved amounts	Generally 80%		Plans A, F, G, M - Generally 20%	Plans A, F, G, M - Nothing
	Part B excess charges (above Medicare approved amounts)	Nothing		Plans A, M – Nothing Plan F – 100% Plan G – 100%	Plans A, M – 100% Plan F – Nothing Plan G – Nothing

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

Date_____

Signature of Applicant_____

M27975_IL

Signature of Agent/Insurance Producer _____





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0605	Mutual of Omaha Insurance Company, Mutual of Omaha	Plaza, Omaha, NE 68175
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*Signature not required for direct response sales