

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

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

<u>Applicant</u> Policy Form	<u>Applicant B</u> 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, or ACH	Initial Mode A, S, Q, B, or ACH
Renewal \$	Renewal \$
Renewal Mode A, S, Q, B (monthly not available)	Renewal Mode A, S, Q, B (monthly not available)

1. PLEASE READ THE FOLLOWING CAREFULLY AND 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 <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
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 _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant Applicant B		
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ / _____ Applicant Applicant B		
3. Did you turn age 65 in the last six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ / _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If "YES," indicate termination date. _____ / _____ / _____ Applicant Applicant B		
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ / _____ Applicant Applicant B		

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed with any of the following?		
A. Kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	

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 reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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)

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Policy Delivery

Mail policy/policies to:

- a) Applicant Producer
- b) Applicant B Producer

Producer(s) Information

Producer Name John Conner Social Security No _____
Comm. % Share _____ Producer Phone No (____) 916-682-1117 Commission Code 0431579
Producer E-mail Address john@johnconner.com @ _____
Producer FAX Number 916-258-0296

Producer Name N/A Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code N/A
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?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) employed, but not working for the business that is paying the premium?	<input type="checkbox"/>	<input type="checkbox"/>
(c) the business owner or spouse of the business owner?	<input type="checkbox"/>	<input type="checkbox"/>

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?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) employed, but not working for the business that is paying the premium?	<input type="checkbox"/>	<input type="checkbox"/>
(c) the business owner or spouse of the business owner?	<input type="checkbox"/>	<input type="checkbox"/>

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

Account Holder Name	Check Number		
John Doe Street Address Town, City Zip code	Check #1234 Date: _____		
Pay to: _____ _____ Dollars			
Bank Name & Address			
Memo _____	Signed By: _____		
⑆123456789⑆ 12345678 ⑆ 1234 ⑆			
Bank Routing/ Transfer Number	Bank Account Number	Check Number (if shown at bottom, may be before or after the account #)	Do NOT include the check number as part of either the Routing or Account Number.

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.

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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.

	Applicant A		Applicant B	
	YES	NO	YES	NO
Medicare Supplement Premium Payment Options:				
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Pay 1st premium by signed paper check and pay monthly renewals by BSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Pay initial premium by ACH and pay renewals by direct bill (monthly direct billing is not offered)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, is the applicant:				
(a) Unemployed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Employed, but not working for the business that is paying the premium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) The business owner or spouse of the business owner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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): <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings
_____ Name of Financial Institution	_____ Name of Financial Institution
_____ Routing Number (first 9 digits on lower left side of check)	_____ Routing Number (first 9 digits on the lower left side of check)
_____ Account Number (Do <u>NOT</u> use Debit or Credit Card account numbers)	_____ Account Number (Do <u>NOT</u> use Debit or Credit Card account numbers)
_____ Name as Shown on Account	_____ 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	Authorized Signature as Shown on Account
Date	Date

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 Rediscovery

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

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

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

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

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

<p>Applicant</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Applicant B</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law 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 for similar benefits to the extent such time was spent under the original policy.
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 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 until you have received your new policy and are sure that you want to keep it.

X _____
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.