

MUTUAL OF OMAHA INSURANCE COMPANY

APPLICATION for INDIVIDUAL LONG-TERM CARE

MISSOURI

MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

MAP395_MO

Long-Term Care Insurance

Application Submission Checklist for Producers

*** TO PREQUALIFY YOUR APPLICANT(S), CALL 800-551-2059.**

*** AFTER COMPLETING THIS APPLICATION, YOU, THE PRODUCER, SHOULD CALL 866-544-1617 TO INITIATE THE PERSONAL HEALTH INTERVIEW.**

Submit the fully completed application, and applicable completed forms. Unanswered questions on the application or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If a question does not apply to your client, answer it as “No” or “None” rather than “N/A.”

If the applicant answers “Yes” to any question in Section D, he/she is ineligible for coverage.

Inform your client(s) that we will conduct a telephone interview or face to face interview. Provide them a copy of “Preparing for the Health Interview.”

Long-Term Care Insurance Personal Worksheet

Complete, sign and submit with application. This worksheet helps determine whether a Long-Term Care policy is suitable.

In order to ensure that the application is completed correctly, please use the following instructions:

Application

1. Sections A-F must be answered in full.
Notes: Any changes must be initialed. Check height/weight build chart to ensure client eligibility.
2. Choose to complete either Section G or H.
3. Section I - Enter the amount of premium and billing mode. Notes: At least two months premium must be submitted with monthly mode. If another mode is selected, submit applicable premium for that mode. There is no policy fee.
4. Sections J-K must be answered in full.

Required Forms to be submitted with Application

- Authorization to Disclose Personal Information (HIPAA)**
- Producer Statement**
- Either a Conditional Receipt or Temporary Insurance Agreement and Receipt (“Agreement”)**
- Long-Term Care Insurance Replacement (if applicable)**
- Foreign National and Foreign Travel Questionnaire (if applicable)**
- Other State Special Forms (if applicable)**

Required Forms left with Applicant(s)

- Copy of either a Conditional Receipt or Temporary Insurance Agreement and Receipt (“Agreement”)**
- MIB Group, Inc. Pre-Notice, Company Notice of Information Practices and Investigative Consumer Reports Notice**
- Long-Term Care Insurance Potential Rate Increase Disclosure Form**
- Things You Should Know Before You Buy Long-Term Care Insurance**
- Senior Health Counseling Notice (if applicable)**
- Other State Special Forms (if applicable)**
- Outline(s) of Coverage**
- LTC Shopper’s Guide**
- Guide to Medicare for People Age 65 and Older**

LONG-TERM CARE INSURANCE

Personal Worksheet

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

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) LTC09M Type of Policy: Guaranteed Renewable Noncancellable Single Premium

Applicant A	Applicant B
The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year or a one-time single premium of \$_____	The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year or a one-time single premium of \$_____

The Company's Right to Increase Premiums

The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state. Once your policy is paid up, the company cannot raise your rates.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2009. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

<u>Policy Form*</u>	<u>Years Available for Purchase</u>	<u>Rate History</u>
NH23/NH24	1987 - 1993	No Rate Increase
LTC1/LTM1	1992 - 1997	No Rate Increase
LT50/NH50	1997 - 2004	No Rate Increase
NHA/LTA/HCA	1998 - 2004	23% overall rate increase 2003
LTC04I	2004 - 2009	No Rate Increase
LTC04I7	2006 - 2009	No Rate Increase
LTC09M	2009 - Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

Questions Related to Your Income

Applicant A

1. How will you pay each year's premium? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.

3. What is your annual income? (Check one)
- Under \$16,000
 \$16,000 and over

4. How do you expect your income to change over the next 10 years? (Check one)
- No Change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

5. Will you buy inflation protection? (Check one)
- Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Applicant B

1. How will you pay each year's premium? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.

3. What is your annual income? (Check one)
- Under \$16,000
 \$16,000 and over

4. How do you expect your income to change over the next 10 years? (Check one)
- No Change Increase Decrease

5. Will you buy inflation protection? (Check one)
- Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

The national average annual cost of nursing home care in 2008 was \$64,605, but this figure varies across the country. In ten years the national average annual cost would be about \$105,234 if costs increase 5% annually.

6. What elimination period are you considering?

Number of days _____

Approximate cost \$ _____ for that period of care.

6. What elimination period are you considering?

Number of days _____

Approximate cost \$ _____ for that period of care.

Multiply the number of days with daily average for approximate cost of care. Reference cost of care sheet for state averages.

7. How are you planning to pay for your care during the elimination period? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

7. How are you planning to pay for your care during the elimination period? (Check one)

- From my Income
 From my Savings/Investments
 My Family will Pay

Questions Related to Your Savings and Investments

Applicant A

1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

- Under \$50,000
 \$50,000 and over

2. How do you expect your assets to change over the next 10 years? (Check one)

- Stay about the same Increase Decrease

Applicant B

1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

- Under \$50,000
 \$50,000 and over

2. How do you expect your assets to change over the next 10 years? (Check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets, not counting your home, are less than \$50,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Applicant A

(must check one)

The answers to the questions on this Personal Worksheet describe my financial situation.

OR

I choose not to complete this information. You may be contacted by a company representative to confirm your decision.

Applicant B

(must check one)

The answers to the questions on this Personal Worksheet describe my financial situation.

OR

I choose not to complete this information. You may be contacted by a company representative to confirm your decision.

Applicant A

◀ THIS BOX MUST BE CHECKED

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**



X

Signature of Applicant A

Date

Applicant B

◀ THIS BOX MUST BE CHECKED

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**



X

Signature of Applicant B

Date

I explained to the applicant(s) the importance of completing this information.

Printed Name of Producer



X

Signature of Producer

Date

Authorization to Proceed when Income less than \$16,000 or Assets less than \$50,000

Applicant A

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.



X

Signature of Applicant A

Date

Applicant B

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.



X

Signature of Applicant B

Date



Submit Application To: Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901
Overnight Submission: Long-Term Care Service Office, 7805 Hudson Rd., Ste. 180, Woodbury, MN 55125-1591

- New Business
- Reinstatement

If Sponsored/Association, List Name and Service Group Number _____

Section A GENERAL INFORMATION

Applicant A

1 Name:

Last Name

First Name

Middle Initial

2 Legal Residence Address:

Number, Street, Apartment Number

City, State, ZIP Code

3 Contact Information:

() - () -
Daytime Phone Number Evening Phone Number

: a.m. : p.m.
Best Time to Call

E-mail Address

4 Social Security Number:

□□□-□□-□□□□

5 Birth Date, Age and Gender:

□□/□□/□□□□ □□
Month Day Year Age

Male Female

6 Occupation and Duties:

Occupation

Occupational Duties

Applicant B

1 Name:

Last Name

First Name

Middle Initial

2 Legal Residence Address (If Different than Applicant A):

Number, Street, Apartment Number

City, State, ZIP Code

3 Contact Information (If Different than Applicant A):

() - () -
Daytime Phone Number Evening Phone Number

: a.m. : p.m.
Best Time to Call

E-mail Address

4 Social Security Number:

□□□-□□-□□□□

5 Birth Date, Age and Gender:

□□/□□/□□□□ □□
Month Day Year Age

Male Female

6 Occupation and Duties:

Occupation

Occupational Duties

Section A

GENERAL INFORMATION (continued)

Applicant A

Applicant B

7 U.S. Citizenship:

Are you a citizen of the United States? Yes No

If "No," do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____

and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

7 U.S. Citizenship:

Are you a citizen of the United States? Yes No

If "No," do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____

and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

8 Beneficiary:

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to you

8 Beneficiary (If Different than Applicant A):

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to you

Section B

ALLOWANCES

You may be eligible for allowances based on your answers to the following questions in this Section B.

1 Are you married?
Do you have a Domestic Partner*?
If "No," go to question 2. If "Yes,":
(a) Is your Spouse or Domestic Partner also applying for this coverage?
If "Yes," provide name
(b) Does he/she have an existing Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company long-term care policy/certificate?
If "Yes," provide existing long-term care policy/certificate number(s)

2 Are you single and have you been continuously residing with another person for the last 12 months and are they also applying for this coverage?
If "Yes," provide name

3 Do you have or are you applying for a Medicare Supplement policy/certificate with Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?
If "Yes," provide existing policy/certificate number(s)

4 Are you a member, or qualified family member, of a Sponsored/Association group endorsing this long-term care product?
If "Yes," provide Sponsored/Association Service Group Number _____
Full Name of Organization _____
Name and Relationship to Member _____

Applicant A

Yes No

Applicant B

Yes No

* Domestic Partner means either of the following: (a) an adult person with whom you have registered or filed for domestic partnership in a civil union with a government agency or office where such registration is available, or (b) an adult person who meets the following criteria: (1) has a serious and committed personal relationship with you that is intended to be lifelong, (2) has shared a common permanent residence on a continuous basis with you for the most recent three years, and (3) is not married or legally separated, a Domestic Partner to anyone else or related to you in any way that would bar marriage in the state where you and he or she reside.

Section C

REPLACEMENT COVERAGE

Provide Replacement Coverage Information.

- 1** Do you currently have another long-term care insurance policy/certificate in force (including health care service contracts or health maintenance organization contracts)?
- 2** Did you have another long-term care insurance policy/certificate in force during the last 12 months?
- 3** Do you intend to replace other long-term care coverage or any of your medical or health insurance coverage with this policy?
If "Yes," please read and sign the Notice to Applicant Regarding Replacement form included with this application.

Applicant A		Applicant B	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 Question to be answered by the Producer:
Have you, **the Producer**, sold any health insurance, including long-term care policies, to Applicant A or Applicant B which: are still in force; or were sold in the last five years but are no longer in force?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

If any question 1-4 was answered "Yes," in the above Section C, please provide details in C5 below.
(Attach additional signed page(s) if more space is needed.)

5 Applicant	Company Name/Address	Policy/Certificate #	Plan Type *	Daily or Monthly Benefit	Status of Policy/Certificate	Annual Premium	To be Replaced by this Coverage	Sold by this Producer
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Provide Plan Type abbreviation: LTC=Long-Term Care, MS=Medicare Supplement, MM=Major Medical, OH=Other Health

Section E

PRIMARY CARE PHYSICIAN INFORMATION AND MEDICATION

1 Provide the name, complete address and phone number of your Primary Care Physician.

	Applicant A	Applicant B (If Different than Applicant A)
Primary Care Physician	_____	_____
Address	_____	_____
City, State, ZIP	_____	_____
Phone Number	_____	_____
2 Date & Reason for Last Visit:	_____	_____

3 Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently? ...
 If "Yes," please list below all the medication name(s) using pharmacy label, dosage/frequency and reason prescribed. (Attach additional signed page(s) if more space is needed.)

Applicant A		Applicant B	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Applicant A	Applicant B
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____

Section F

ADDITIONAL HEALTH QUESTIONS

	Applicant A		Applicant B	
	Yes	No	Yes	No
1 Do you have, or have you ever received any advice, treatment, consultation or diagnosis from a physician or health care provider for any of the following conditions?				
Alcohol or Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or Blood Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Back, Bone or Joint Disorder or Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance Disorder, Difficulty Walking or Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or other Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia, Weakness or Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Disorder or High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune System Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Liver Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, Epilepsy or Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you scheduled for, or have you been advised by a physician or health care provider to have additional testing, surgery or consultation(s) to evaluate your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Are there any pending test results which you have not yet received?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Do you have, for your use, a handicap parking sticker or handicap license plate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you used tobacco in any form in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 What is your height?	' "		' "	
9 What is your weight?	lbs		lbs	

Section F**ADDITIONAL HEALTH QUESTIONS (continued)**

If "Yes" to any additional health questions of Section F, please provide the following for each "Yes" answer below.
 (Attach additional signed page(s) if more space is needed.)

Applicant A

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

Applicant B

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

INSTRUCTIONS: Complete Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – OR – Section H for MUTUAL CARE MY WAY.

INFLATION PROTECTION: You have the option to purchase a 5% Compound Inflation Protection (Lifetime) benefit. Neither MUTUAL CARE 3 nor MUTUAL CARE 5 offer the 5% Compound Inflation Protection (Lifetime) benefit. If you want to purchase this benefit – SKIP Section G and complete Section H for MUTUAL CARE MY WAY. Check the first box in H7.

Section G MUTUAL CARE 3 – OR – MUTUAL CARE 5

Applicant A **Applicant B (If selecting Spouse Shared Care Benefit, benefits must be identical to Applicant A)**

1 Select Mutual Care 3 or Mutual Care 5 (must check one): **1 Select Mutual Care 3 or Mutual Care 5 (must check one):**

Mutual Care 3

- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

Mutual Care 3

- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

Mutual Care 5

- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

Mutual Care 5

- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

2 Acknowledgement (must check): **2 Acknowledgement (must check):**

I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

3 Maximum Monthly Benefit (MMB) (must enter): **3 Maximum Monthly Benefit (MMB) (must enter):**

\$, per month
(\$3,000-\$15,000 in \$500 increments)

\$, per month
(\$3,000-\$15,000 in \$500 increments)

4 Nonforfeiture Benefit – Shortened Benefit Period (must check “YES” or “NO”): **4 Nonforfeiture Benefit – Shortened Benefit Period (must check “YES” or “NO”):**

YES

NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired: I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

YES

NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired: I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

OPTIONAL BENEFIT FOR MUTUAL CARE 3 – OR – MUTUAL CARE 5

5 Spouse Shared Care Benefit
Only available when both Spouses or Domestic Partners apply at the same time and both policies are issued with identical benefits.

If you completed Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – SKIP Section H and continue to Section I.

If MUTUAL CARE 3 or MUTUAL CARE 5 was selected – SKIP Section H.

Section H

MUTUAL CARE MY WAY

If you are customizing your plan – COMPLETE this Section H.

Applicant A

Applicant B (If selecting Spouse Shared Care Benefit, benefits must be identical to Applicant A)

1 Maximum Monthly Benefit (MMB) (must enter):

\$, per month
(\$1,500-\$15,000 in \$500 increments)

1 Maximum Monthly Benefit (MMB) (must enter):

\$, per month
(\$1,500-\$15,000 in \$500 increments)

2 Maximum Lifetime Benefit = number of months selected x MMB (must check one):

- 2 Year (24 months) 3 Year (36 months)
 4 Year (48 months) 5 Year (60 months)
 6 Year (72 months) 8 Year (96 months)
 Lifetime

2 Maximum Lifetime Benefit = number of months selected x MMB (must check one):

- 2 Year (24 months) 3 Year (36 months)
 4 Year (48 months) 5 Year (60 months)
 6 Year (72 months) 8 Year (96 months)
 Lifetime

3 Assisted Living Facility Benefit as a Percentage of the Maximum Monthly Benefit (must check one):

Up to: 50% 75% 100%

3 Assisted Living Facility Benefit as a Percentage of the Maximum Monthly Benefit (must check one):

Up to: 50% 75% 100%

4 Home Health Care Benefit as a Percentage of the Maximum Monthly Benefit (must check one):

Up to: 50% 75% 100%

4 Home Health Care Benefit as a Percentage of the Maximum Monthly Benefit (must check one):

Up to: 50% 75% 100%

5 Cash Benefit – 35% of Home Health Care Benefit (automatically included)

5 Cash Benefit – 35% of Home Health Care Benefit (automatically included)

6 Calendar Day Elimination Period (must check one):

- 0 Day 30 Day 60 Day
 90 Day 180 Day 365 Day

6 Calendar Day Elimination Period (must check one):

- 0 Day 30 Day 60 Day
 90 Day 180 Day 365 Day

7 Inflation Protection:

5% Compound (Lifetime)
(must check "YES" or "NO"):

- YES, I am selecting the 5% Compound Inflation Protection (Lifetime)
 NO, 5% Compound Inflation Protection (Lifetime) is NOT desired: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

If you selected "NO" to the 5% Compound (Lifetime), check one Inflation Option below:

- 5% Simple (Lifetime)
 5% Compound (20 Year)
 4% Compound (Lifetime)
 3% Compound (Lifetime)
 No Inflation Protection with Future Purchase Option

7 Inflation Protection:

5% Compound (Lifetime)
(must check "YES" or "NO"):

- YES, I am selecting the 5% Compound Inflation Protection (Lifetime)
 NO, 5% Compound Inflation Protection (Lifetime) is NOT desired: I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

If you selected "NO" to the 5% Compound (Lifetime), check one Inflation Option below:

- 5% Simple (Lifetime)
 5% Compound (20 Year)
 4% Compound (Lifetime)
 3% Compound (Lifetime)
 No Inflation Protection with Future Purchase Option

Insurance Specialties
 7505 State Hwy 37 / PO Box 275
 Purdy MO 65734
 800-789-0182
 www.insspecial.com

Applicant A

8 Nonforfeiture Benefit – Shortened Benefit Period

(must check "YES" or "NO"):

YES

NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired: I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Applicant B

8 Nonforfeiture Benefit – Shortened Benefit Period

(must check "YES" or "NO"):

YES

NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired: I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

OPTIONAL BENEFITS FOR MUTUAL CARE MY WAY

9 Waiver of Elimination Period for Home Health Care Benefit

9 Waiver of Elimination Period for Home Health Care Benefit

10 Spousal Benefits:

The **Spouse Waiver of Premium, Spouse Survivorship Benefit** and **Spouse Shared Care Benefit** are only available when both Spouses or Domestic Partners apply at the same time and both policies are issued.

Spouse Waiver of Premium

Spouse Survivorship Benefit

Spouse Shared Care Benefit

The **Spouse Shared Care Benefit** is only available when both policies are issued with identical benefits.

10

11 Spouse Security Benefit

Not available for issue ages 70 and older, with Spousal Benefits or if Spouse or Domestic Partner is applying for this coverage.

Spouse's or Domestic Partner's Name

11

12 Restoration of Benefits

Not available with Lifetime Benefits.

12 Restoration of Benefits

Not available with Lifetime Benefits.

13 Additional Benefit for Injury

13 Additional Benefit for Injury

14 5 Years of Rate Guarantee

14 5 Years of Rate Guarantee

15 Return of Premium at Death Benefit:

Return of Premium (Less Claims Paid) If Death Occurs Before Age 65

OR

Return of Premium at Death (Less Claims Paid)

OR

Full Return of Premium at Death

15 Return of Premium at Death Benefit:

Return of Premium (Less Claims Paid) If Death Occurs Before Age 65

OR

Return of Premium at Death (Less Claims Paid)

OR

Full Return of Premium at Death

Continue to Section I.

Section I

PREMIUM INFORMATION

Applicant A

Applicant B

1 Premium Options (must check one):

- Lifetime
- Single Premium
- 10-Year Pay
- 20-Year Pay
- To-Age-65

1 Premium Options (must check one):

- Lifetime
- Single Premium
- 10-Year Pay
- 20-Year Pay
- To-Age-65

2 Premium Amount:

Modal Premium: \$ _____

Premium Collected: \$ _____
- Two Months Minimum

2 Premium Amount:

Modal Premium: \$ _____

Premium Collected: \$ _____
- Two Months Minimum

3 Recurring Premium Mode (check one unless Single Premium):

- Monthly Automatic Checking Account (.09) Deduction
Specify the date premiums will be withdrawn
(1st through the 28th of the month): _____

Bank Name _____

Routing Number

--	--	--	--	--	--	--	--	--	--

Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Or include a voided check.)

3 Recurring Premium Mode (check one unless Single Premium):

- Monthly Automatic Checking Account (.09) Deduction
Specify the date premiums will be withdrawn
(1st through the 28th of the month): _____

Bank Name _____

Routing Number

--	--	--	--	--	--	--	--	--	--

Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Or include a voided check.)

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

I authorize Mutual of Omaha Insurance Company (Mutual of Omaha) to withdraw funds from my account for my initial and/or renewal premiums and understand that the amounts may differ. I also authorize Mutual 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 Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.



X

Signature of Applicant A

Date



X

Signature of Applicant B

Date

Direct Bill:

- Quarterly (.26)
- Semiannual (.51)
- Annual (1.0)

Billing Address for Premium Notices
(if different from page 1):

Name

Street Address, Apartment Number

City, State, ZIP Code

Direct Bill:

- Quarterly (.26)
- Semiannual (.51)
- Annual (1.0)

Billing Address for Premium Notices
(if different from page 1):

Name

Street Address, Apartment Number

City, State, ZIP Code

4 Select Effective Date:

- Date of Application
- Date Policy is Issued
- For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

4 Select Effective Date:

- Date of Application
- Date Policy is Issued
- For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

Section J

NOTICE BEFORE LAPSE OR TERMINATION

Please check the applicable box and complete the requested information. You may want to consider designating someone other than a Spouse or Domestic Partner.

Applicant A

- I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

Name (Print full name of other person to receive notice of lapse or termination)

Street Address, Apartment Number

City, State, ZIP Code

Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

OR

- I elect NOT to designate any person to receive such notice.

Applicant B

- I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

(If Different than Applicant A)

Name (Print full name of other person to receive notice of lapse or termination)

Street Address, Apartment Number

City, State, ZIP Code

Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

OR


- I elect NOT to designate any person to receive such notice.


1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha Insurance Company may require: an Attending Physician's Statement, medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement), and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force.
4. Applicant agrees that there is no temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions of the Conditional Receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the long-term care coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest.
5. Applicant acknowledges that no Producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. Applicant acknowledges receipt of an Outline of Coverage, Shopper's Guide to Long-Term Care Insurance, Potential Rate Increase Disclosure Form and, if applicable, *Guide to Health Insurance for People with Medicare*.

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

Caution: If your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company has the right to deny benefits or rescind your policy.


I have read and understand this Agreements and Acknowledgements Section, including the Fraud Warning and I approve all my answers as recorded in this application.

Signed at _____	
City	State
 X	
Signature of Applicant A	Date

Signed at _____	
City	State
 X	
Signature of Applicant B	Date

I/We, the Producer(s) certify that each question was asked exactly as written and I/we have recorded the answers provided by the Applicant(s) completely and accurately. I/We also agree that my/our answers in this application are true and complete.

Yes No (If "No," please explain) _____

 **X**

Signature of Licensed Producer(s) _____

Insurance Specialties
 7505 State Hwy 37 / PO Box 275
 Purdy MO 65734
 800-789-0182
 www.insspecial.com

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, consumer reporting agencies and any other organization, institution, or person that has records or knowledge of me or my health to release personal information about me to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Personal information includes my health information such as medical history, mental or physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may include my entire medical record.

The Personal information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or in connection with a claim.



I also authorize Mutual to disclose my personal information to the MIB. I understand that my personal information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy. I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

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

Printed Name of Applicant A		Birth State and County		Printed Name of Applicant B		Birth State and County	
 X				 X			
Signature of Applicant A		Date		Signature of Applicant B		Date	

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

MLU26722

- | | | |
|--|------------------------------------|------------------------------------|
| | Yes | No |
| 1. I/We certify that the Notice of Information Practices and Investigative Consumer Reports Notice were given to the Applicant(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. I/We certify that each question was asked exactly as written and that I/we recorded the answers completely and accurately in the presence of the Applicant(s).....
(If "No," explain) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. This coverage is written on myself (the Producer) and/or my Spouse or Domestic Partner | <input type="checkbox"/> | <input type="checkbox"/> |
| | Applicant A | Applicant B |
| 4. Please indicate the Underwriting Risk classification quoted.....
Your quote will be noted, however, Underwriting will determine the final risk classification. We suggest quoting Select unless our Underwriting Guide indicates the health condition(s) warrants a substandard rating. Class II cases should be discussed with an underwriter prior to application submission. | <input type="checkbox"/> Preferred | <input type="checkbox"/> Preferred |
| | <input type="checkbox"/> Select | <input type="checkbox"/> Select |
| | <input type="checkbox"/> Class I | <input type="checkbox"/> Class I |
| | <input type="checkbox"/> Class II | <input type="checkbox"/> Class II |
| 5. To the best of my knowledge, replacement of other insurance (check box) involved in this transaction | <input type="checkbox"/> is | <input type="checkbox"/> is |
| If replacement is involved, I/we shall comply with all state and/or company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application. | <input type="checkbox"/> is not | <input type="checkbox"/> is not |

	X	Signature of Producer (Agent of Record)	Date
	X	Signature of Other Producer, if applicable	Date

Producer Information (please print clearly)

For Mutual of Omaha Career Producers Only: 01	DSM Stamp	Producer Stamp
Manager Stamp		

For Brokerage Only: Commission Code			951300	(Examples: 8 8 , A 2 , etc.)
(- Commission code available from your marketing organization.)				

Producer's Name _____ (Agent of Record)	Social Security Number _____
Comm. % Share _____	Producer's Phone Number () _____
Producer's Identification Number _____	Producer's E-mail Address _____
Other Producer's Name _____ (If applicable, for Commission Split)	Social Security Number _____
Comm. % Share _____	Producer's Phone Number () _____
Producer's Identification Number _____	Producer's E-mail Address _____

Whom should we contact with questions regarding this application if different than Producer listed above:	
Name _____	
Name of Office/Corporation _____	
Phone Number () _____	
Fax Number () _____	
E-mail Address _____	

SUBMIT TO LTC SERVICE OFFICE

Appendix 3

CONDITIONAL RECEIPT

Initial Premium paid by check

Applicant A

Received from **Applicant A** the sum of \$ _____ paid as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Applicant B

Received from **Applicant B** the sum of \$ _____ paid as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Total Premium
\$ _____


(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK. DO NOT COLLECT PREMIUMS FOR SINGLE PREMIUM CASES.)


This receipt is given and accepted with the understanding that the insurance applied for by each applicant will become effective on the date of the completed application (unless a later date is selected by the applicant, in which case coverage will become effective on the date selected by the applicant) if all of the following conditions have been fully satisfied:

1. the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company,
2. Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement),
3. the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force, and the policy is issued, and
4. the insurance applicant has paid the first full premium according to the method of payment selected in the application.

Mutual of Omaha Insurance Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, Mutual of Omaha Insurance Company will return monies received with the application if (a) the coverage, other than applied for, is offered but not accepted, or (b) if the coverage is declined. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application for coverage.

This is not a temporary insurance agreement and does not create any temporary or interim insurance.

Signed at _____	
City	State
 X	
Signature of Applicant A	Date

Signed at _____	
City	State
 X	
Signature of Applicant B	Date

 X
Signature of Licensed Producer(s)

Appendix 3

CONDITIONAL RECEIPT

Initial Premium paid by check

Applicant A

Received from Applicant A the sum of \$ _____ paid as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Applicant B

Received from Applicant B the sum of \$ _____ paid as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Total Premium \$ _____

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK. DO NOT COLLECT PREMIUMS FOR SINGLE PREMIUM CASES.)

This receipt is given and accepted with the understanding that the insurance applied for by each applicant will become effective on the date of the completed application (unless a later date is selected by the applicant, in which case coverage will become effective on the date selected by the applicant) if all of the following conditions have been fully satisfied:

- 1. the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company,
2. Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement),
3. the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force, and the policy is issued, and
4. the insurance applicant has paid the first full premium according to the method of payment selected in the application.

Mutual of Omaha Insurance Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, Mutual of Omaha Insurance Company will return monies received with the application if (a) the coverage, other than applied for, is offered but not accepted, or (b) if the coverage is declined. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application for coverage.

This is not a temporary insurance agreement and does not create any temporary or interim insurance.

Signed at City State
Signature of Applicant A Date

Signed at City State
Signature of Applicant B Date

Signature of Licensed Producer(s)

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Appendix 5

COMPANY NOTICE OF INFORMATION PRACTICES

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

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, LONG-TERM CARE SERVICE OFFICE, P.O. BOX 64901, ST. PAUL, MN 55164-0901.

Appendix 6

INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

IMPORTANT INFORMATION REGARDING “MISSOURI’S LONG-TERM CARE INSURANCE PARTNERSHIP” PROGRAM

Disclosure Notice

Partnership policy status.

Insurance companies can voluntarily agree to participate in the Missouri long-term care insurance partnership program by offering long-term care insurance policies that meet certain state and federal requirements (partnership plan). Our company has chosen to participate in this program. Therefore, the long-term care insurance policy you are considering purchasing qualifies as a partnership plan.

What does this mean to you?

Under the partnership program, if you own a long-term care insurance policy that qualifies as a partnership plan, you may be able to protect some of your assets from Medicaid’s “spend down” requirements if you should ever have to apply for Medicaid benefits. For example, if you have a policy that qualifies as a partnership plan, you may be able to shield one dollar of your assets under Medicaid for every dollar of benefits the policy pays for your long-term care. **Please note that the purchase of a partnership plan does not automatically qualify you to receive benefits under Medicaid.** Medicaid has certain requirements that must be met in order to receive benefits under a state Medicaid program.

What could disqualify a plan as a partnership plan?

If any changes are made to the plan once it has been purchased, these changes could affect whether the plan will continue to be qualified as a partnership plan. Therefore, if you purchase a partnership plan, ***before you make any change to the plan (e.g., decrease the level of benefits),***

you should consult with us to determine the effect of the proposed change. In addition, if you should move to a state that does not maintain a partnership program or does not recognize the policy as a qualified partnership plan under the laws of that state, any payment of long-term care benefits under the policy would not protect your assets under the Medicaid program.

State and federal law governing partnership plan policies

The information contained in this notice is based on current Missouri and federal laws. However, please be aware that these laws are subject to change at any time in the future, which changes could result in the modification, reduction or even the elimination of the Medicaid-asset protection feature.

Questions?

Should you have questions regarding the long-term care insurance partnership program policy you are considering purchasing or have purchased, please contact _____ at _____.

If you have questions about Missouri’s long-term care partnership program or questions about long-term care insurance in general, please call the Missouri Department of Insurance, Financial Institutions & Professional Registration at 1-800-726-7390. You may also access more information at the following web sites.

<http://www.difp.mo.gov>

<http://www.dss.mo.gov>

LONG-TERM CARE INSURANCE

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

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

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.


STATEMENT TO APPLICANT BY PRODUCER

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.


1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of 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 are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

	X
	Signature of Producer
	Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

	X		
		Signature of Applicant A	Date

	X		
		Signature of Applicant B	Date

LONG-TERM CARE INSURANCE

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

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

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.


STATEMENT TO APPLICANT BY PRODUCER

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.


1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of 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 are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

	X
_____ Signature of Producer	
_____ Printed Name and Address of Producer	

The above Notice to Applicant was delivered to me on:

	X		
		Signature of Applicant A	Date

	X		
		Signature of Applicant B	Date

LONG-TERM CARE INSURANCE

POTENTIAL RATE INCREASE DISCLOSURE FORM

This is not applicable to single premium.

1. **Premium Rate:** Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is: Applicant A \$ _____
Applicant B \$ _____
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:**
The premium rates for this policy may change. Any change will be effective on the next billing date after the company has provided you at least 60 days written notice before we change premiums.
4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

*Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the greater of the total amount of premiums you've paid since your policy was first issued or the maximum monthly benefit. If you have already received benefits under the policy, so that the remaining lifetime maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

**CONTINGENT NONFORFEITURE
CUMULATIVE PREMIUM INCREASE OVER INITIAL PREMIUM
THAT QUALIFIES FOR CONTINGENT NONFORFEITURE**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced “paid up” benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced “paid up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

**TRIGGERS OF SUBSTANTIAL
PREMIUM INCREASE**

ISSUE AGE	% INCREASE OVER INITIAL PREMIUM
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The maximum monthly benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the maximum monthly benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

LONG-TERM CARE INSURANCE

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. This is not applicable to single premium.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

MEDICARE

Medicare does **not** pay for most long-term care.

MEDICAID

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

SHOPPER'S GUIDE

Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

COUNSELING

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

FACILITIES

Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Foreign National and Foreign Travel Questionnaire



TO BE COMPLETED BY PROPOSED INSURED(S) OR POLICYOWNER(S) – PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY

- 1** Are you a U.S. citizen? Yes No
(If "Yes," proceed to Question 2.)
- (a) Are you a Permanent Resident (holder of a Permanent Resident Card)? Yes No
(1) If "Yes," please list your Permanent Resident Card Number: _____
(2) If "No," please list the type of visa you hold: _____ How long have you lived in the United States? _____
- (b) Please provide your full name as stated on the Permanent Resident Card or Visa: _____

- (c) Date of issue on your Permanent Resident Card or Visa: _____
- (d) Date of expiration on your Permanent Resident Card: _____
- (e) Country of Birth: _____
- (f) Do you own a home in the United States? Yes No
If "Yes," please provide the address: _____
- (g) Do you own a home in a foreign country? Yes No
If "Yes," please provide the address: _____
- (h) If married, does your family live with you in the United States? Yes No
- 2** Are you employed in the United States? Yes No
- (a) If "Yes," please provide the name and address of your employer and describe the duties you perform. _____

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

- 3** Do you plan to travel outside of the United States in the next two years? Yes No
(If "Yes," please answer the following questions below:)
- (a) Where do you plan to travel? _____
- (b) What is the purpose of travel? Business Pleasure
- (c) How often? _____
- (d) Average period of time for each trip: _____
- (e) What was the date of your last trip? _____

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

Signature(s) of Proposed Insured(s) _____ Date _____

Signature(s) of Policyowner(s) _____ Date _____

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

Signature(s) of Producer(s) _____ Date _____

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7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

LONG-TERM CARE INSURANCE

Preparing for the Personal Health Interview

WHAT IS THE PERSONAL HEALTH INTERVIEW?

Completing a personal health interview is your next step in applying for a long-term care insurance policy. The interview – typically conducted by a registered nurse – is used to assess your eligibility for long-term care insurance.

HOW IS THE INTERVIEW CONDUCTED?

Your insurance agent will set up the interview for you at your convenience.

- If you are age 71 or younger, the interview will be conducted over the telephone and will take approximately 30 to 45 minutes to complete
- If you are age 72 or older, the interview will be conducted in person and will take approximately one hour

WHAT QUESTIONS WILL I BE ASKED?

You will be asked a series of questions about your current health, the medications you take and your daily activities. Questions also will be asked to evaluate your memory and mental ability. The questions are not difficult, and will include things like:

- The name of your primary care physician and any specialists you see
- The names of the medications you take
- Your future plans for surgery, medical testing or medical consultation

- Your living arrangements and social activities
- Your use of medical devices, such as a wheelchair

WHY IS THE INTERVIEW SO IMPORTANT?

The information you provide will be used to determine if you are eligible for a long-term care insurance policy. For that reason, it's important to give the interviewer your full attention and answer all questions completely and accurately.

- Turn off the television or radio
- Move to a quiet spot where you will not be distracted
- Make sure you can hear the interviewer clearly
- Answer all questions to the best of your ability
- If a distraction should occur while the interview is being conducted, please let the nurse know and ask to reschedule the interview for a better time

YOUR INFORMATION IS STRICTLY CONFIDENTIAL

We protect your privacy by safeguarding the information you provide. Mutual of Omaha Insurance Company will use the contents of your personal health interview solely during the application process for long-term care insurance and will not release the information without your written authorization.

USE THIS FORM TO PREPARE FOR THE PERSONAL HEALTH INTERVIEW

Take a few minutes now to collect the following information so you'll be prepared for your personal health interview.

Primary Care Physician

Name: _____
Address: _____
City, State, ZIP: _____
Phone Number: _____
Date/Reason Last Seen: _____

Specialist

Name: _____
Address: _____
City, State, ZIP: _____
Phone Number: _____
Date/Reason Last Seen: _____

Current Medications (prescription and over-the-counter)

Name: _____ Name: _____
Dosage: _____ Dosage: _____
Frequency: _____ Frequency: _____

Name: _____ Name: _____
Dosage: _____ Dosage: _____
Frequency: _____ Frequency: _____

Name: _____ Name: _____
Dosage: _____ Dosage: _____
Frequency: _____ Frequency: _____

YOUR PERSONAL HEALTH INTERVIEW REFERENCE NUMBER

You will be provided a reference number when you complete your personal health interview.
Record that number here: _____