

**UNITED OF OMAHA LIFE INSURANCE COMPANY**  
A MUTUAL of OMAHA COMPANY  
P.O. Box 3608 Omaha, Nebraska 68103-3608



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# APPLICATION for MEDICARE SUPPLEMENT INSURANCE

## ARKANSAS

**Med Supp e-App...to be sure**



Try it today on Sales Professional Access  
or contact Sales Support.

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**Ins-Special, Inc**  
7505 State Hwy 37 / PO Box 218  
Purdy, MO 65734  
[service@insspecial.com](mailto:service@insspecial.com)  
800-789-0182

UAP1132\_AR  
08/10/2011

## 2011 Medicare Supplement Insurance Plans



### *Spontaneous. **FUN!**Fearless.*

Whether you're six or sixty something, playing keeps you young-at-heart. The difference now, of course, is that you have adult responsibilities, including making sound financial decisions.

You'll probably enjoy playing, however you define it, even more when you feel you've got your bases covered.

A Medicare supplement insurance policy from United of Omaha Life Insurance Company can help you attain that secure feeling.

***With a Medicare supplement, you***

- *Keep your doctors and health care providers*
- *See specialists without referrals*
- *Receive benefits with no waiting period\**
- *Enjoy guaranteed coverage for life\**

Add our helpful midwestern customer service staff and affordable premiums – including a discount for your eligible spouse or household resident – and you have the financial value and security you seek.

*\*see details on back cover*

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Underwritten by

**UNITED OF OMAHA LIFE INSURANCE COMPANY**  
A MUTUAL of OMAHA COMPANY  
Mutual of Omaha Plaza  
Omaha, NE 68175  
[mutualofomaha.com](http://mutualofomaha.com)

United of Omaha Life Insurance Company is licensed nationwide except in NY.

**We've got you covered. *GO PLAY!***

## Select the Medicare Supplement Plan that's Right for You

	Medicare Pays	Plan A Pays	Plan F Pays	Plan G Pays	Plan M Pays	Plan N Pays
<b>Medicare Part A Hospital Insurance*</b>						
Deductible	Nothing		\$1,132	\$1,132	\$566 (50%)	\$1,132
First 60 days	100%					
Coinsurance 61-90 days	All but \$283 a day	\$283 a day	\$283 a day	\$283 a day	\$283 a day	\$283 a day
Coinsurance 91-150 days	All but \$566 a day	\$566 a day	\$566 a day	\$566 a day	\$566 a day	\$566 a day
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	Nothing	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints	Three pints	Three pints
<b>Skilled Nursing Facility Care</b>						
First 20 days	100%					
Coinsurance 21-100 days	All but \$141.50 a day		Up to \$141.50 a day	Up to \$141.50 a day	Up to \$141.50 a day	Up to \$141.50 a day
<b>Hospice Care</b>						
Outpatient Prescription Drugs	All but \$5	\$5	\$5	\$5	\$5	\$5
Inpatient Respite Care	All but 5%	5% of Medicare's approved amount	5% of Medicare's approved amount	5% of Medicare's approved amount	5% of Medicare's approved amount	5% of Medicare's approved amount
<b>Medicare Part B Medical Insurance*</b>						
Deductible	Nothing		\$162			
Coinsurance	80%	20%	20%	20%	20%	20%**
Excess Benefits			100% up to Medicare's limit	100% up to Medicare's limit		
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints	Three pints	Three pints
<b>Additional Benefit*</b>						
Emergency Care Received Outside the U.S.	Nothing		80% to lifetime max of \$50,000	80% to lifetime max of \$50,000	80% to lifetime max of \$50,000	80% to lifetime max of \$50,000

\* Refer to the next page and your outline of coverage for more information.

\*\* Requires up to a \$20 copayment for an office visit and up to a \$50 copayment for an emergency room visit.

<b>Your Premium</b>	<b>Your Premium</b>	<b>Your Premium</b>	<b>Your Premium</b>	<b>Your Premium</b>
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

## Medicare Part A Hospital Coverage

*Medicare Part A hospital/skilled nursing facility care eligible expenses include charges for semiprivate room and board, general nursing and miscellaneous services and supplies.*

**Deductible** – Plans F, G and N pay the \$1,132 inpatient hospital deductible (Plan M pays \$566 of the deductible) for each benefit period, which begins the first full day you're hospitalized and ends when you haven't been in a hospital or skilled nursing facility for 60 days in a row.

**Coinsurance** – All plans pay \$283 a day when you're hospitalized from the 61st through the 90th day. And, when you're in the hospital from the 91st day through the 150th day, you receive \$566 a day for each Lifetime Reserve day used.

**Extended Hospital Coverage** – When you're in the hospital longer than 150 days during a benefit period, and you've exhausted your 60 days of Medicare Lifetime Reserve, all plans pay the Medicare Part A

eligible expenses for hospitalization, paid at the rate Medicare would have paid, subject to a lifetime maximum benefit of an additional 365 days.

**Benefit for Blood** – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

## Skilled Nursing Facility Care Benefit

**Coinsurance** – Plans F, G, M and N pay up to \$141.50 a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

## Hospice Care Benefit

**Outpatient Prescription Drugs** – All plans pay \$5 per prescription for outpatient prescription drugs for pain and symptom management.

**Inpatient Respite Care** – All plans pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest).

## Medicare Part B Medical Coverage

*Medicare Part B eligible expenses include charges for physicians' services, hospital outpatient services and supplies, physical and speech therapy and ambulance service.*

**Deductible** – Plan F pays the \$162 calendar-year deductible.

**Coinsurance** – After the Medicare Part B deductible, all plans pay 20% of eligible expenses. With Plan N, you pay up to a \$20 copayment for an office visit and up to a \$50 copayment for an emergency room visit.

For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then 20% of eligible expenses will be paid.

**Excess Benefits** – Your bill for Medicare Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

**Benefit for Blood** – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

## Additional Benefit

**Emergency Care Received Outside the U.S.** – After you pay a \$250 calendar-year deductible, Plans F, G, M and N pay you 80% of eligible expenses for health

care you need because of a covered injury or illness beginning during the first 60 days of each trip up to a lifetime maximum of \$50,000.

## Plan Overview

Your United of Omaha Medicare supplement insurance policy helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and United of Omaha pay. If you receive Medicare benefits because of a disability, you may apply for a supplement policy regardless of your age.**

Your Medicare supplement does not pay for:

- any expense incurred before your policy date
- hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force

- expense paid for by Medicare
- services for non-Medicare eligible expenses
- services for which no charge is made when there is no insurance
- loss or expense that is payable under any other Medicare supplement insurance policy or certificate

Medicare eligible expenses means charges of the kinds covered by Medicare Parts A and B, to the extent Medicare recognizes them as reasonable and medically necessary.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by United of Omaha.

## Features Give You More Peace of Mind

**You're covered immediately.** There is no waiting period for preexisting conditions and benefits will be paid from the time your policy is in force.

**Your policy cannot be canceled.** It will be renewed as long as the premiums are paid on time and the information is correct on your application.

**Your Medicare supplement benefits will automatically increase** as Medicare deductibles and coinsurance increase. Benefits are not paid for any expense paid by Medicare.

**Benefits are paid to you, your hospital or doctor.**

**You have 31 days from your renewal date to pay your premium.** Your policy will stay in force during this 31-day grace period.

**You can't be singled out for a rate increase, no matter how many times you receive benefits.** Your premium changes: (a) each year on the renewal date coinciding with or following the anniversary of your policy date until you reach age 90; and (b) when the same premium change is made on all in-force Medicare supplement policies of the same form issued to persons of your classification in your state. Your policy's two-person household premium discount ends if the person you live with terminates his or her policy or moves to a different residence.



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**This is a brief description of your coverage.** The outline of coverage must accompany this brochure. For complete information on benefits, exceptions, limitations and reductions, please read your outline of coverage and your policy.

**This is a solicitation of insurance and an insurance agent will contact you by telephone.**

Neither United of Omaha Life Insurance Company nor its Medicare supplement insurance policies are connected with or endorsed by the U.S. government or the federal Medicare program.



## Open Enrollment and Guaranteed Issue Worksheet

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

### ELIGIBILITY FOR OPEN ENROLLMENT

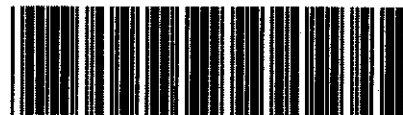
#### Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

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

### ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.



#### Applicant:

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

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

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

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

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

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

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

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

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

#### Acceptable Evidence of Eligibility:

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

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan    Applicant A \_\_\_\_\_

Applicant B \_\_\_\_\_



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

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	<b>Age</b> Write in your age at the time of signing the application. <b>ZIP Code</b> Indicate your ZIP Code used to determine your rate.	65  51502		
#2	<b>Premium</b> Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	<b>Household Premium Discount</b> Does a member of your household: (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are married either have an existing Medicare supplement plan with, or are applying for coverage with, Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company? <b>If yes,</b> multiply the amount from Step #2 by .93. <b>If no,</b> enter the amount from Step #2.	$\$128.52 \times .93 =$ \$119.52  In this example, the person qualifies for the household premium discount.		
#4	<b>Rate Adjustment</b> <i>If you're in your open enrollment or guaranteed issue period, skip to Step #5.</i> <b>Locate your height, then weight on the next page.</b> <ul style="list-style-type: none"> <li>If your weight is in the Standard column, enter the amount from Step #3</li> <li>If your weight is in the Class I or II column, multiply the amount from Step #3 by:                             <ul style="list-style-type: none"> <li>1.10 if in Class I column</li> <li>1.20 if in Class II column</li> </ul> </li> </ul>	$\$119.52 \times 1.20 =$ \$143.42  Person's weight is in the Class II column.		
#5	<b>Payment Options</b> Your monthly payment is your last premium entered (Step #3 or #4). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$143.42 monthly payment  \$430.26 quarterly payment \$860.52 semiannual payment \$1,721.04 annual payment		

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## Height and Weight Chart

### Eligibility

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

### Rate Adjustment

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

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

Medicare supplement insurance is underwritten by  
**UNITED OF OMAHA LIFE INSURANCE COMPANY**  
 A MUTUAL of OMAHA COMPANY  
 Mutual of Omaha Plaza  
 Omaha, Nebraska 68175  
 mutualofomaha.com



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Agent Writing #

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FAV Key \_\_\_\_\_

Auth # \_\_\_\_\_

Group # (if applicable) \_\_\_\_\_

Keyline \_\_\_\_\_

# UNITED OF OMAHA LIFE INSURANCE COMPANY

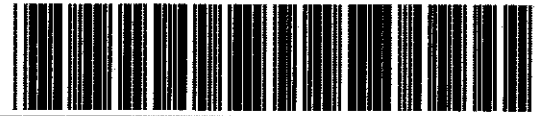
A MUTUAL of OMAHA COMPANY

Ins-Special, Inc  
7505 State Hwy 37 / PO Box 218  
Purdy MO 65734  
800-789-0182  
www.insspecial.com



## Application for Medicare Supplement Coverage

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



### A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan M	Plan (select one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan M
Requested Effective Date: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]	Requested Effective Date: [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ]
Deliver Policy to Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>	Deliver Policy to Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>

### B. Applicant Information

Applicant A	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP [ ] [ ] [ ] [ ] [ ] [ ]	State ZIP [ ] [ ] [ ] [ ] [ ] [ ]
Home Phone [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] (area code)	Home Phone [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] (area code)
E-mail Address	E-mail Address
Current Age _____	Current Age _____
Date of Birth [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] mo day yr	Date of Birth [ ] [ ] / [ ] [ ] / [ ] [ ] [ ] [ ] mo day yr
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]	Social Security # [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ]
Height Ft [ ] In [ ] [ ] Weight Lbs [ ] [ ] [ ] [ ]	Height Ft [ ] In [ ] [ ] Weight Lbs [ ] [ ] [ ] [ ]

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## B. Applicant Information (continued)

**Applicant A**

**Applicant B**

**Go paperless!** To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United of Omaha.

Receive statement online? .....  Y  N

Receive statement online? .....  Y  N

## C. Medicare Information

Please reference your Medicare card to complete this section.



<b>MEDICARE HEALTH INSURANCE</b>	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY <b>JANE DOE</b>	
MEDICARE CLAIM NUMBER <b>000-00-0000-A</b>	SEX <b>FEMALE</b>
IS ENTITLED TO HOSPITAL (PART A) →	EFFECTIVE DATE <b>07-01-2010</b>
MEDICAL (PART B) →	<b>07-01-2010</b>

**Applicant A**

**Applicant B**

Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>
Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>

## D. Household Premium Discount Information

**You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.**

1. Does a member of your household:
- (a) with whom you have continuously resided for the last 12 months; or
  - (b) to whom you are married
- either have an existing Medicare supplement plan with, or are applying for coverage with United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?.....

**Applicant A**

**Applicant B**

Y  N

Y  N

2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)

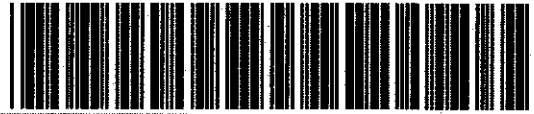
Policy Number

Street Address

City/State/ZIP

UA5978-03

## E. Previous or Existing Coverage Information



If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) <b>If "YES," answer the following about this existing coverage:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**Please answer questions regarding another Medicare supplement or Select plan:**

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this existing coverage:</b>		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

**Please answer questions regarding Medicare plan coverage (other than Medicare supplement):**

5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	Applicant A <input type="checkbox"/> Y <input type="checkbox"/> N	Applicant B <input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant A END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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	Check box(es) below if applicable	
	Applicant A	Applicant B
(g) Please indicate reason for termination/disenrollment:		
■ Your Medicare Advantage plan is leaving the Medicare program.....	<input type="checkbox"/>	<input type="checkbox"/>
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....	<input type="checkbox"/>	<input type="checkbox"/>
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....	<input type="checkbox"/>	<input type="checkbox"/>
■ You moved out of the geographic service area of your Medicare Advantage plan.....	<input type="checkbox"/>	<input type="checkbox"/>
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....	<input type="checkbox"/>	<input type="checkbox"/>
■ Other: _____		
Applicant A _____		
Applicant B _____		

**Please answer questions regarding other health insurance:**

	Applicant A	Applicant B
6. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(b) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(c) With what company and what kind of policy/certificate? (List below.)		

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

**F. Please answer all of the following questions:**

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Did you turn age 65 in the last six months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Did you enroll in Medicare Part B in the last six months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," indicate your effective date.....</b>	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>

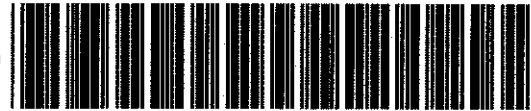
**IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, SKIP SECTIONS G & H AND GO TO SECTION I.**

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

**G. Health Information**

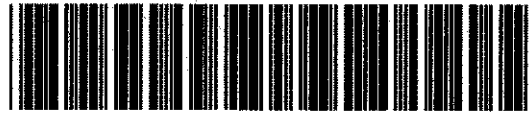


**For all plans, answer questions 10-19.**

(If "YES" is answered to any of the following questions 10-18, that person is not eligible for coverage.)

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

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## H. Medication Information

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

### Applicant A

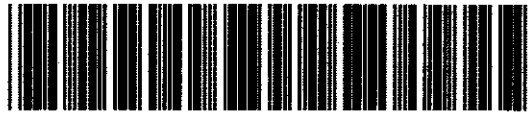
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

### Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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# I. Agreement and Authorization



## IMPORTANT STATEMENTS

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

## AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED OF OMAHA LIFE INSURANCE COMPANY

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

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

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

**Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.**

Dated at \_\_\_\_\_, on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_, \_\_\_\_\_  
 City State Month Day Year Applicant A's Signature

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

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UNITED OF OMAHA LIFE INSURANCE COMPANY • P.O. Box 3608 • Omaha, Nebraska 68103-3608

Ins-Special, Inc  
 7505 State Hwy 37 / PO Box 218  
 Purdy MO 65734  
 800-789-0182  
[www.insspecial.com](http://www.insspecial.com)



**METHOD OF PAYMENT FORM**

**REQUIRED FORM – PLEASE RETURN**

**Part I. Select Premium Payment Option**

<b>Initial Premium (Select option #1 or #2)</b> Initial premium amount (based on age at application date) 1. Paper Check (submit signed check with application)..... 2. Automated Bank Account Withdrawal..... <b>Ongoing Premium Payments (Select option #1 or #2)</b> 1. I want my payments automatically withdrawn from my bank account every month on (Circle date)..... 2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	<b>Applicant A</b> \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 <sup>st</sup> or 15 <sup>th</sup> every _____ months Insert 3, 6, or 12	<b>Applicant B</b> \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 <sup>st</sup> or 15 <sup>th</sup> every _____ months Insert 3, 6, or 12
--	---	---


**Part II. Payor Information**

Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account): 1. Account Owner Name, if different than applicant's..... 2. Account Owner Relationship to applicant: Employer _____ Living Trust _____ Power of Attorney or legal guardian (documentation required) _____ Business owned by applicant or applicant's spouse _____	<b>Applicant A</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>Applicant B</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
--	--	--

**Part III. Account Information**

Complete the following ONLY if Automated Bank Account Withdrawal is Chosen:  
 This section is intended as authorization to debit your bank account.  
 Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here	<b>Applicant A</b> Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____	<b>Applicant B</b> <input type="checkbox"/> Same account as Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____
------------------------------	---	--

- Payments cannot be postponed until a later date.
  - Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
  - All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.
- 

**Example:**

Account Holder Name	Do NOT include the check # in the Routing or Account Number
John Doe Street Address Town, City ZIP Code	Check #1234 Date: _____
Pay to: _____	
Routing/Transfer Number	Account Number Dollars
Financial Institution Name & Address	
Signed By: _____	
⑆223456789⑆ 12345678 ⑆ 1234 ⑆	

**IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.**  
 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. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to United of Omaha any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

_____ Authorized Signature as Shown on Account _____ Date	_____ Authorized Signature as Shown on Account _____ Date
--	--

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy 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><b>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 Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Applicant B</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 Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	---

If, you still wish to terminate your present policy or certificate 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 or certificate until you have received your new policy and are sure that you want to keep it.



**Signature of Agent, Broker or Other Representative\***

**Date**

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.

U7563

U7563

Ins-Special, Inc  
 7505 State Hwy 37 / PO Box 218  
 Purdy MO 65734  
 800-789-0182  
[www.insspecial.com](http://www.insspecial.com)

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Documentation of Solicitation of Medicare Related Products

In accordance with Arkansas law, this form is to be completed for all Medicare Supplement, Medicare Advantage and Medicare Part D solicitations, where an application was completed. Place completed form in client file.

I certify that the solicitation of Medicare related product coverage for \_\_\_\_\_  
(Client's Name)

was solicited in the following manner.

- All replacement questions were asked and recorded on the application.  
This application  was  was not a replacement.
  - If a replacement, I have reviewed the applicants current coverage and made a best effort to adequately inform the Medicare beneficiary of any substantial benefit differences between replaced and new coverages.
  - If a replacement, I have advised the Medicare beneficiary they have the right to contact the issuer of the policy that is being replaced for additional information
- The Medicare beneficiary signed the application
- A copy of the Outline of Coverage was left with the Medicare beneficiary

 \_\_\_\_\_  
Agent's Name

\_\_\_\_\_  
Date



**Complete and Retain in Applicant's File**

U7715

U7715

## IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

**Replacement Notice**

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

**Premium Receipt / Notice of Information Practices**

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy 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):

<b>Applicant</b>	<b>Applicant B</b>
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____

If, you still wish to terminate your present policy or certificate 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 or certificate until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_ **Signature of Agent, Broker or Other Representative\*** \_\_\_\_\_ **Date**  
 UNITED of OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

<b>Applicant</b>	<b>Applicant B</b>
Signature	Signature
Date	Date

\*Signature not required for direct response sales.

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# UNITED OF OMAHA LIFE INSURANCE COMPANY

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## Premium Receipt

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

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

### Applicant A

Received from \_\_\_\_\_

this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

an application for Form \_\_\_\_\_ Policy

and/or Riders \_\_\_\_\_ and

Check for \_\_\_\_\_ Dollars.

### Applicant B

Received from \_\_\_\_\_

this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

an application for Form \_\_\_\_\_ Policy

and/or Riders \_\_\_\_\_ and

Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

 Agent \_\_\_\_\_

**No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, United of Omaha Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.**



## Notice of Information Practices

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

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

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

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

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

Provide the completed premium receipt, if applicable, and notice to the applicant.