Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

MUTUAL of OMAHA

LUMP SUM PORTFOLIO

CRITICAL ADVANTAGE ($10,000 - $100,000)

- CANCER
- HEART ATTACK & STROKE
- CRITICAL ILLNESS

Application for Supplemental Health Insurance

TEXAS

Application Package Contains:

REQUIRED FORMS TO BE SUBMITTED	REQUIRED FORMS LEFT WITH APPLICANT(S)
• Authorization to Disclose Personal Information (HIPAA)/ MIB Authorization Form • Agent Producer Statement • Other State Special Forms (if applicable)	• Pre-Notices • Outline(s) of Coverage • Other State Special Forms (if applicable)

FORMS THAT MAY BE REQUESTED, BUT ARE NOT INCLUDED WITHIN THIS PACKAGE

The following form can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application:

- Replacement Notice

Application Instructions:

- Submit the fully completed application and applicable completed forms. Unanswered questions on the application or missing or incomplete forms will result in underwriting delays.
- If a question does not apply to your client, answer it as "No" or "None" rather than "N/A."
- Partner signature is required on all family coverage amounts.
- **Mail application and appropriate forms to: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175.**
- **Fax application to 402-997-1804 and verify the correct facsimile number is dialed to protect the privacy of the information.**

Please note: use the maximum resolution to ensure the readability of the application.

MAP628_TX
7/1/2018

Manager/Commission Code (Required Field for Brokerage)

Mutual of Omaha Insurance Company

Application for Supplemental Health Insurance

MUTUAL of OMAHA

GENERAL INFORMATION

A. Coverage(s) Applying For

1. Type of Coverage: ☐ Individual ☐ Individual plus child(ren) ☐ Family

2. Coverage Options: ☐ Guaranteed for lifetime ☐ 10-year term ☐ 15-year term ☐ 20-year term ☐ 30-year term

3. Product: (Select only one)

☐ Lump Sum Cancer (Complete Sections 1 and 2)

☐ Lump Sum Heart Attack and Stroke (Complete Sections 1 and 3)

☐ Lump Sum Critical Illness (Complete Sections 1, 2, 3 and 4)

5. Optional Riders:

☐ $250 ☐ $500 ☐ $750 ☐ $1,000 Intensive Care Unit Indemnity Benefits Rider (Complete Section 5)

☐ Cancer Benefits Rider $ _____ (Complete Section 2)

☐ Heart Attack and Stroke Benefits Rider $ _____ (Complete Section 3)

4. Base Lump Sum Benefit Amount $_____

Note: The lump sum benefit amount for any child(ren) under an applicable policy will equal the amount of the Primary Insured up to $50,000. Must select benefit in increments of $1,000.

B. Proposed Insured Information

Proposed Insured's Name (First, Middle, Last)	Sex ☐ Female ☐ Male	Date of Birth / /	Email Address
Primary Residence Address (Number, Street, City, State, Zip)	Ht (ft.-in.)	Wt	Social Security Number - -
Mailing Address for Premium Notices (if different than primary address)	Telephone Number ( ) _____-_____	Best Time to Call _____ A.M. P.M.	
Full Name of Beneficiary	Relationship to Proposed Insured		

Are all applicants U.S. citizens or Permanent Resident Card holders who have resided in the U.S. for 3 years? Yes ☐ No ☐

If "No," Name(s) _____

C. All Other Persons Proposed For Insurance

Relationship	Name (First, Middle, Last)	Date of Birth	Birth State	SS#	Age	Sex	Ht. (ft.-in.)	Wt.
Partner *		/ /		- -				

Relationship	Name (First, Middle, Last)	Date of Birth	Sex
Child #1		/ /	
Child #2		/ /	
Child #3		/ /	
Child #4		/ /	

* Partner means the one person who is (a) your spouse to whom you are legally married; (b) your registered domestic partner; or (c) an adult person who: 1. shares a serious and committed personal relationship with you that is intended to be lifelong; 2. has shared a common permanent residence with you on a continuous basis for the most recent three years; 3. is not married, a domestic partner, a civil union partner, or in a committed personal relationship to anyone else; and 4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

D. Other Coverage and Replacement Information

Is the coverage applied for replacing any existing coverage for any Proposed Insured? . . . . . Yes ☐ No ☐
If "Yes", please give details below.

Company	Proposed Insured	Face Amount	Termination Date

E. HEALTH QUESTIONS

Please answer the questions below for the insurance type you are applying.
If the answer is Yes, any individual named will be excluded from coverage under this policy.

Section 1: All Insurance Applied For:

1. Has any Proposed Insured been diagnosed by a medical professional with or treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Aids Related Complex (ARC)? . . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

Section 2: Cancer Insurance Applied For:

1. Within the past 10 years, has any Proposed Insured been diagnosed with, treated or consulted with a medical professional for internal cancer, malignant tumors, lymphoma, leukemia or melanoma?. . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

2. Within the past 3 years, has any Proposed Insured been advised by a medical professional to undergo treatment, testing or had tests performed where the results are pending, not been received, abnormal or inconclusive for which a medical professional has not ruled out cancer? . . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

Section 3: Heart Attack and Stroke Insurance Applied For:

1. Within the past 10 years, has any Proposed Insured been diagnosed with, treated, been advised to have treatment, prescribed medication, hospitalized or consulted with a medical professional for any disease, disorder or abnormality of the heart or blood vessels, excluding high blood pressure or cholesterol which is considered controlled by a medical professional? . . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

2. Within the past 3 years, has any Proposed Insured been advised by a medical professional to undergo treatment, testing or had tests performed where the results are pending, not been received, abnormal or were inconclusive for which a medical professional has not ruled out a heart or blood vessel condition(s)? . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

3. Has any Proposed Insured been diagnosed with diabetes? (Type 1, Type II diagnosed under age of 30, A1C greater than 7.0 within the last 12 months, or with tobacco use) (Except for Gestational Diabetes)?. . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

Section 4: Critical Illness Insurance Applied For:

1. Within the past 10 years, has any Proposed Insured been diagnosed with, or treated, prescribed medication, hospitalized or consulted with a medical professional for any of the following? (Check all that apply)

- ☐ Kidney Function
- ☐ Alzheimer's Disease/Dementia/Cognitive Impairment
- ☐ Chronic Liver Disease (to include Cirrhosis, Hepatitis B & C)
- ☐ Eye or Ear Disorder/Disease
- ☐ Neurological Condition (such as Multiple Sclerosis, Parkinson's, Seizures, Muscular Dystrophy)
- ☐ Organ Transplant
- ☐ Pulmonary Fibrosis
- ☐ Severe Chronic Lung Disease
- ☐ **None of These**

If condition has been checked above, indicate who _____

2. Within the past 3 years, has any Proposed Insured been advised by a medical professional to undergo treatment, testing, or had tests performed where the results are still pending, not been received, abnormal or were inconclusive for any medical condition?. . . . . ☐ **Yes** ☐ **No**
If "Yes," who? _____

Section 5: Intensive Care Unit Benefit Rider Insurance Applied For:

1. Is any Proposed Insured currently bedridden, hospital confined, in a nursing home or assisted living facility, or confined to a wheelchair? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
2. Has any Proposed Insured been diagnosed and/or treated with any disease or disorder of the lung, liver, connective tissue, brain or nervous system? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
3. Has any Proposed Insured been advised to have surgery that has not been performed or recently had surgery from which he/she is not fully recovered? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
4. Is any Proposed Insured currently pregnant? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**

AGREEMENTS AND ACKNOWLEDGEMENTS

PLEASE READ AND SIGN

1. Applicant ("you") represents that my answers on this application are true and complete. Incorrect or misleading answers may void this application and any issued policy from its effective date.
2. Mutual of Omaha Insurance Company ("we" or "us") may require medical records, a medical exam or other information. This coverage will not be approved unless we receive all information requested for underwriting and determined you are eligible for the exact insurance applied for as of the application date or you have accepted an offer by us for coverage other than for which you applied. If approved, the policy will indicate its effective date.
3. This application does not provide temporary insurance. If this application is declined, any advance premium payment submitted with the application will be refunded without interest. No insurance coverage will be in effect until we issue a policy and receive payment of the full initial premium according to the premium mode you selected with your application.
4. No producer can waive or change any receipt or policy provision or agree to issue a policy.

I have (a) read and understand the Agreements and Acknowledgements; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline of Coverage as required.

Signed at: _____
City State

_____ _____ _____
Signature of Proposed Insured Printed Name of Proposed Insured Date

_____ _____ _____
Signature of Partner* Printed Name of Partner* Date

Producer Section:

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . . . ☐ Yes ☐ No

(If "No," please explain.)_____

_____

_____ _____ _____ _____
Signature of Producer Producer's Printed Name Producer # Date

_____ _____
Office Name Office Address

_____ _____ _____ _____
Signature of Producer Producer's Printed Name Producer # Date

_____ _____
Office Name Office Address

AGENT/PRODUCER STATEMENT

Proposed Insured: _____

CONTACT INFORMATION

Division Office/MGA _____ Phone Number _____

Contact (if different than above, who should we contact on this case)

Name _____ Phone Number _____

E-mail Address _____

COMMISSION INFORMATION

Producer Name _____ Production Number _____

Last 4 digits of Social Security Number _____ Commission % Share _____

If second producer, please complete below:

Producer Name _____ Production Number _____

Last 4 digits of Social Security Number _____ Commission % Share _____

ADDITIONAL INFORMATION

Does any person proposed for insurance currently have, or is such person applying for, Critical Illness (lump-sum diagnostic benefits) coverage with any company?..... ☐ Yes ☐ No

If "Yes," give details including the name(s) of such person(s), name of the company, policy/plan number and termination date. _____

_____

Has the MIB, LLC Pre-Notice and the Notice of Information Practices been provided to the Proposed Insured where applicable?..... ☐ Yes ☐ No

If applying for spouse, enter spouse's name _____

Deliver Policy to: ☐ Applicant ☐ Producer

Comments or Special Instructions:

_____

_____

_____

_____

_____

_____

Agent/Producer Signature _____ Date _____
Month/Day/Year

Agent/Producer Signature _____ Date _____
Month/Day/Year

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
800-775-6000

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

Payment Information

Premium Quoted $_____

1. First Premium Payment (check one)

☐ Automated Bank Account Withdrawal

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AT POLICY ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

☐ Check Submitted With Application Amount of Check $_____

2. Ongoing Premuim Payments (check one)

☐ Monthly Automatic Bank Account Deduction* (check one)

☐ 1st through 28th or last day of the month _____

-OR

☐ Choose the week and weekday that payments will be deducted every month payments are due. (For example, 3rd Wednesday), (circle week and weekday)

- Week (1st 2nd 3rd 4th Last) _____
- Weekday (Mon Tue Wed Thurs Fri) _____

☐ Direct Bill (not available on Monthly mode)

☐ Quarterly ☐ Annual
☐ Semi-annual

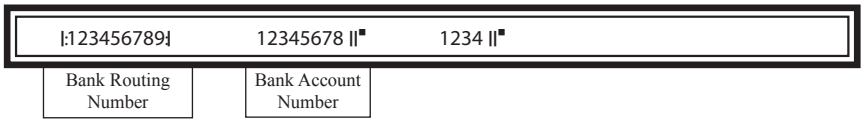
* Each "month", payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is "issued". If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day.

Account Information

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)



Name of payor as shown on bank account: _____

If premium is NOT paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

☐ Employer
☐ Business owned by Proposed Insured/Insured or Spouse
☐ Power of Attorney or legal guardian
☐ Living Trust
☐ Spouse
☐ Other _____

Authorization

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the 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 my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify Mutual of Omaha in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date _____ X _____

Mo./Day/Yr. Authorized Signature as Shown on Account

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

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

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. 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.

I understand that 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 be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand 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. A 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.

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

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

_____

_____ **Date:** _____
Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) Mo Day Yr

_____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) Mo Day Yr

_____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Acknowledgement of Nonduplication

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

PLEASE READ CAREFULLY BEFORE SIGNING

I, X _____
Producer's Name
certify that I have done the following.

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of the policy.
2. Reviewed the policies listed below and have found that duplication WILL ☐ or WILL NOT ☐ *(check one)* occur with the issuance of the applied-for policy.

_____
(Form Number(s))

COMPANY	POLICY NUMBER	TYPE OF POLICY

Check one:

☐ (a) Duplication will not occur because the above-listed policy number(s) _____ will be replaced by the applied-for policy _____ *(form number(s))*. Justification for the replacement is *(explain benefit to consumer)*

_____
_____

☐ (b) No health policies in force at this time.

☐ (c) Applicant has elected not to have the policy (policies) reviewed.

X _____ _____
Signature of Producer Date

NOTICE TO CONSUMERS AGE 65 AND OLDER

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
   - SPECIFIED DISEASE (CANCER, STROKE, ETC.).
   - HOSPITAL INDEMNITY.
   - BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS).
   - LONG-TERM CARE.

   THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.
2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES, YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS OR WAITING PERIODS MUST BE SERVED.
4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE PRODUCER OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant A Date

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant B Date

Company Copy

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

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 notifications on the following pages are to be left with applicant(s).

Mutual of Omaha Insurance Company - MIB, LLC Pre-Notice

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, LLC which operates an information exchange on behalf of insurance companies that are members of the MIB Group, Inc. 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. 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 Park, 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.

M26978_1022

Applicant's/Owner's Copy

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

M20180

Acknowledgement of Nonduplication

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

PLEASE READ CAREFULLY BEFORE SIGNING

I, X _____
Producer's Name
certify that I have done the following.

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of the policy.
2. Reviewed the policies listed below and have found that duplication WILL ☐ or WILL NOT ☐ *(check one)* occur with the issuance of the applied-for policy.

_____
(Form Number(s))

COMPANY	POLICY NUMBER	TYPE OF POLICY

Check one:

☐ (a) Duplication will not occur because the above-listed policy number(s) _____ will be replaced by the applied-for policy _____ *(form number(s))*. Justification for the replacement is *(explain benefit to consumer)*

_____
_____

☐ (b) No health policies in force at this time.

☐ (c) Applicant has elected not to have the policy (policies) reviewed.

X _____ _____
Signature of Producer Date

NOTICE TO CONSUMERS AGE 65 AND OLDER

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   - SPECIFIED DISEASE (CANCER, STROKE, ETC.).
   - HOSPITAL INDEMNITY.
   - BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS).
   - LONG-TERM CARE.

   THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.
2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES, YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS OR WAITING PERIODS MUST BE SERVED.
4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE PRODUCER OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant A Date

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant B Date

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

MUTUAL OF OMAHA INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

LUMP SUM CANCER INSURANCE COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR POLICY CP1

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Cancer Insurance Coverage – Policies of this category are designed to provide benefits ONLY when certain losses occur as a result of specified diseases. Coverage is NOT provided for other diseases or accidents.

BENEFITS – If a physician diagnoses an insured person with cancer while this policy is in force, we will pay 100% of the lump sum benefit shown on the policy schedule. Once we have paid 100% of the lump sum benefit for the primary insured, this policy will end, unless lump sum benefits continue under an attached rider.

COVERED CONDITION LIMITATION – The policy pays benefits only for loss resulting from cancer. It does NOT cover any other type of sickness or injury, unless such other coverage has been added by rider.

EXCLUSIONS – We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION – The policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the policy effective date.

A pre-existing condition is a condition:

(a) for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within 12 months prior to the policy effective date; or
(b) which manifested itself within 12 months prior to the policy effective date in a manner that would have caused a reasonably prudent person to seek diagnosis, care or treatment by a physician.

30-DAY PROBATIONARY PERIOD – The policy has a 30-day probationary period for cancer. Subject to the Pre-Existing Condition Limitation provision requirements, in order to be covered, cancer must be:

(a) diagnosed while this policy is in force; and
(b) diagnosed at least 30 days after the policy effective date or at least 30 days after any policy reinstatement date.

If an insured person is diagnosed with cancer during the policy probationary period, we will not pay benefits for that insured person. Coverage for that insured person will end as of the policy effective date. We will refund any unearned premium for that insured person.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD – The policy is guaranteed renewable until we pay 100% of the primary insured's lump sum benefit, or until the term period shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before the end of each grace period.

GRACE PERIOD – The policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period. If the premium has not been paid during the grace period and a claim is payable during the grace period, we can deduct the premium payment from any payment of the claim.

PREMIUMS CAN CHANGE – We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the policy effective date.

Total premium amount _____

MUTUAL OF OMAHA INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

HEART ATTACK AND STROKE INSURANCE COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR POLICY CP2

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Heart Attack and Stroke Insurance Coverage – Policies of this category are designed to provide benefits ONLY when certain losses occur as a result of specified diseases. Coverage is NOT provided for other diseases or accidents.

BENEFITS – If a physician diagnoses an insured person with a covered condition while this policy is in force, we will pay a percentage of the lump sum benefit. The percentage payable for each type of covered condition is listed below. If we pay less than 100% of the lump sum benefit for a type of covered condition, the lump sum benefit remaining available for future claims for that insured person will be reduced by that amount. We will not reduce your policy's premium when a portion of the lump sum benefit is paid. Once we have paid 100% of the lump sum benefit for the primary insured, this policy will end, unless lump sum benefits continue under an attached rider.

Type of Covered Condition	Percentage of Lump Sum Benefit Payable
Heart Attack (Myocardial Infarction)	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE during the life of your policy)**

COVERED CONDITION LIMITATION – The policy pays benefits only for loss resulting from a covered condition. It does NOT cover any other type of sickness or injury, unless such other coverage has been added by rider.

EXCLUSIONS – We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION – The policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the policy effective date.

A pre-existing condition is a condition:

(a) for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within 12 months prior to the policy effective date; or
(b) which manifested itself within 12 months prior to the policy effective date in a manner that would have caused a reasonably prudent person to seek diagnosis, care or treatment by a physician.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD – The policy is guaranteed renewable until we pay 100% of the primary insured's lump sum benefit, or until the term period shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before the end of each grace period.

GRACE PERIOD – The policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period. If the premium has not been paid during the grace period and a claim is payable during the grace period, we can deduct the premium payment from any payment of the claim.

PREMIUMS CAN CHANGE – We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the policy effective date.

Total premium amount _____

MUTUAL OF OMAHA INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

LUMP SUM CRITICAL ILLNESS INSURANCE COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR POLICY SERIES CP4

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Critical Illness Insurance Coverage – Policies of this category are designed to provide benefits ONLY when certain losses occur as a result of specified diseases. Coverage is NOT provided for other diseases or accidents.

BENEFITS – If a physician diagnoses an insured person with a covered condition while this policy is in force, we will pay a percentage of the lump sum benefit. The percentage payable for each type of covered condition is listed below. If we pay less than 100% of the lump sum benefit for a type of covered condition, the lump sum benefit remaining available for future claims for that insured person will be reduced by that amount. We will not reduce your policy's premium when a portion of the lump sum benefit is paid. Once we have paid 100% of the lump sum benefit for the primary insured, this policy will end, unless lump sum benefits continue under an attached rider.

Type of Covered Condition	Percentage of Lump Sum Benefit Payable
Alzheimer's Disease	**100%**
Blindness	**100%**
Cancer	**100%**
Deafness	**100%**
Heart Attack (Myocardial Infarction)	**100%**
Kidney (Renal) Failure	**100%**
Major Organ Transplant	**100%**
Paralysis	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE during the life of your policy)**

RETURN OF PREMIUM AT DEATH BENEFIT – If you die while your policy is in force, we will pay a lump sum return of premium at death benefit to your beneficiary. If your beneficiary is deceased, or cannot be located, we will pay this benefit to your estate.

The amount we pay will be 100% of all premiums you paid for your policy and attached riders, minus the amount of benefits, including return of premium and cash value benefits, we paid under your policy and attached riders, if any. The premiums we return will be calculated without interest after we have finalized all pending claims. If a loss is incurred prior to your death, but we do not receive notice of it until after we have paid the return of premium at death benefit, we will reduce any benefits we pay for the claim by the amount we

paid for the return of premium at death benefit. If the amount of benefits we paid exceeds the amount of premiums you paid for your policy and riders, no return of premium benefit will be payable.

COVERED CONDITION LIMITATION – The policy pays benefits only for loss resulting from a covered condition. It does NOT cover any other type of sickness or injury, unless such other coverage has been added by rider.

EXCLUSIONS – We will not pay benefits for:

(a) loss that occurs while this policy is not in force;
(b) loss resulting from service in the armed forces or auxiliary units;
(c) loss caused by intentionally self-inflicted injury, while sane or insane;
(d) loss resulting from an insured person's commission or attempted commission of a felony;
(e) loss sustained while engaging in an illegal occupation;
(f) loss resulting from an insured person being intoxicated (as determined and defined by the laws of the jurisdiction in which the loss or cause of loss occurred; for the purposes of this exclusion, the laws governing the operation of motor vehicles while intoxicated will apply); or
(g) loss resulting from an insured person being under the influence of any controlled substance (except for narcotics given on the advice of a physician).

PRE-EXISTING CONDITION LIMITATION –The policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the policy effective date.

A pre-existing condition is a condition:

(a) for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within 12 months prior to the policy effective date; or
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(b) diagnosed at least 30 days after the policy effective date or at least 30 days after any policy reinstatement date.

If an insured person is diagnosed with cancer during the policy probationary period, we will not pay benefits for that insured person. Coverage for that insured person will end as of the policy effective date. We will refund any unearned premium for that insured person.

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Total premium amount _____