



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

**APPLICATION for
INDIVIDUAL DENTAL INSURANCE
WITH OPTIONAL VISION RIDER**

MINNESOTA



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

MINNESOTA							
ZIP Codes	Mutual Dental Preferred DNT2			Mutual Dental Protection DNT5			Vision Rider OPD1M
	\$1,500	\$3,000	\$5,000	\$1,500	\$3,000	\$5,000	
557-566	\$52.98	\$60.67	\$63.32	\$29.04	\$29.86	\$30.41	\$8.28
550-556, 567	\$63.58	\$72.80	\$75.98	\$34.85	\$35.83	\$36.49	\$8.28

Rates Subject to Change.

As of 10/05/2023

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to \$50 every calendar year for one eye exam (no waiting period)

Up to \$150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

Internal Tracking Code _____
 Group # (if applicable) _____



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3300 Mutual of Omaha Plaza
 Omaha, Nebraska 68175

Application for Individual Dental Insurance with Optional Vision Rider



A. Applicant Information

Name (First, Middle Initial, Last)		Phone Number Home _____ Cell _____	
Residence Address (Street, City, State, ZIP)		E-mail _____	
Mailing Address (Street, City, State, ZIP) (if different from residence address)		Deliver Policy to <input type="checkbox"/> Applicant <input type="checkbox"/> Producer	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Social Security Number* _____	

*Your Social Security Number is requested to support accurate and timely claim processing on your plan. It does not have any impact on your application or enrollment.

B. Plan Information

Select Dental Benefit Plan <input type="checkbox"/> Mutual Dental Preferred <input type="checkbox"/> Mutual Dental Protection	Select Annual Maximum <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000	Requested Effective Date _____ Monthly Premium Rate for Dental \$ _____ Monthly Premium Rate for Vision \$ _____ Total Monthly Premium \$ _____
<input type="checkbox"/> Optional Vision Rider (only available with Dental)		

C. Existing Coverage Information

Are you covered by any other dental or vision insurance? Y N

If Yes, answer the following about this existing coverage:

Name of dental carrier(s) _____

Name of vision carrier(s) _____

Is the coverage you are applying for replacing existing dental insurance? Y N

Is the coverage you are applying for replacing existing vision insurance? Y N

D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

 Applicant Signature _____ Date _____ Signed at _____ City _____ State _____

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

 Signature of Licensed Insurance Producer _____ Date _____

 Printed Name _____ Agent Writing Number _____ Comm. % Share _____%

 Signature of Licensed Insurance Producer _____ Date _____

 Printed Name _____ Agent Writing Number _____ Comm. % Share _____%

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Part IV. 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

Applicant A

Account Type (check one): Checking 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	Check #1234
Street Address	Date: _____
Town, City ZIP Code	Pay to: _____
Routing/Transfer Number	Account Number Dollars
Financial Institution Name & Address	Signed By: _____
Memo	
[23456789]	12345678 1234

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 the business 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.

Applicant A



Authorized Signature as Shown on Account

Date



Mutual of Omaha Insurance Company – Notice of Information Practices

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

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

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

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

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

M26977

GIVE THIS NOTICE TO THE APPLICANT

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MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

**INDIVIDUAL DENTAL PREFERRED PROVIDER
ORGANIZATION (PPO) INSURANCE**

**THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the
“Guide to Health Insurance for People with Medicare” available from us.**

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!**

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you **ONLY** with limited benefit dental insurance coverage. Coverage is **NOT** provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	\$50.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	TIME FRAME
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000
Implant Lifetime Maximum Benefit	\$3,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for

the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
 - 1. equilibration;
 - 2. periodontal splinting;
 - 3. full mouth rehabilitation and;
 - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;

- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ff) use of material or home health aids to prevent decay, such as:
 1. toothpaste;
 2. fluoride gels;
 3. dental floss and;
 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
 1. lost;
 2. stolen or;
 3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
 1. extractions;
 2. apicoectomies or;
 3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
- (uu) space maintainers;
- (vv) services or treatment provided by a member of your immediate family;
- (ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

Premiums Can Change – We will not increase your policy’s premium due to any change in your health. 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 the advance notice required by your state prior to any such premium change.

Loss Ratio – The anticipated loss ratio is 65% for the dental policy and 70% for the vision rider. This ratio is the portion of future premiums, which the company expects to return as benefits, when averaged over all people with this policy.

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**MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600**

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

**INDIVIDUAL DENTAL PREFERRED PROVIDER
ORGANIZATION (PPO) INSURANCE**

**THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

**If you are eligible for Medicare, review the
“Guide to Health Insurance for People with Medicare” available from us.**

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!**

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you **ONLY** with limited benefit dental insurance coverage. Coverage is **NOT** provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services, Class II – Basic Services and Class III – Major Services Combined	\$100.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	TIME FRAME
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000
Implant Lifetime Maximum Benefit	\$2,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the

PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is experimental or investigational;
- (d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (f) services or treatment performed prior to the policy effective date;
- (g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
- (i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (j) telephone consultations;
- (k) any charges for failure to keep a scheduled appointment;
- (l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (m) fluoride treatments;
- (n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (p) office infection control charges;
- (q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- (r) state, federal, or territorial taxes on dental services performed;
- (s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (v) those dental services which are for specialized procedures and techniques;
- (w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (x) duplicate, provisional and temporary devices, appliances, and services;
- (y) plaque control programs, oral hygiene instruction, and dietary instructions;
- (z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
 - 1. equilibration;
 - 2. periodontal splinting;
 - 3. full mouth rehabilitation and;
 - 4. restoration for misalignment of teeth;
- (aa) gold foil restorations;
- (bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (dd) charges by the provider for completing dental forms;

- (ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ff) use of material or home health aids to prevent decay, such as:
 1. toothpaste;
 2. fluoride gels;
 3. dental floss and;
 4. teeth whiteners;
- (gg) sealants;
- (hh) precision attachments, personalization, precious metal bases and other specialized techniques;
- (ii) replacement of dentures that have been:
 1. lost;
 2. stolen or;
 3. misplaced;
- (jj) repair of damaged orthodontic appliances;
- (kk) replacement of lost or missing appliances;
- (ll) fabrication of athletic mouth guard;
- (mm) internal bleaching;
- (nn) nitrous oxide;
- (oo) oral sedation;
- (pp) topical medicament carrier;
- (qq) orthodontic services, treatment or supplies, including braces and retainers;
- (rr) bone grafts when done in connection with:
 1. extractions;
 2. apicoectomies or;
 3. non-covered/non-eligible implants;
- (ss) tooth whitening;
- (tt) occlusal guards;
- (uu) space maintainers;
- (vv) services or treatment provided by a member of your immediate family; or
- (ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

Premiums Can Change – We will not increase your policy’s premium due to any change in your health. 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 the advance notice required by your state prior to any such premium change.

Loss Ratio – The anticipated loss ratio is 65% for the dental policy and 70% for the vision rider. This ratio is the portion of future premiums, which the company expects to return as benefits, when averaged over all people with this policy.

