Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

APPLICATION for

INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

NEW MEXICO

MAP642_NM
02/28/2024

Mutual of Omaha | Underwritten by Mutual of Omaha Insurance Company | 3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

NEW MEXICO							
ZIP Codes	**Mutual Dental Preferred DNT2**			**Mutual Dental Protection DNT5**			**Vision Rider 0PD1M**
	$1,500	$3,000	$5,000	$1,500	$3,000	$5,000	
877-885	$51.19	$58.61	$61.17	$28.35	$29.15	$29.68	$13.76
870-875	$53.94	$61.76	$64.46	$29.87	$30.71	$31.27	$13.76

Rates Subject to Change.

As of 03/15/2024

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) _____

MUTUAL of OMAHA

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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 (may be used for delivery of policy)
Mailing Address (Street, City, State, ZIP) (if different from residence address)	

Gender ☐ Male ☐ Female	Date of Birth	Social Security Number	Deliver Policy to ☐ Applicant ☐ Producer

B. Plan Information

Select Dental Benefit Plan	**Select Annual Maximum**	
☐ Mutual Dental Preferred ☐ Mutual Dental Protection	☐ $1,500 ☐ $3,000 ☐ $5,000	**Requested Effective Date** _____ **Monthly Premium Rate for Dental $** _____
☐ Optional Vision Rider (only available with Dental)		**Monthly Premium Rate for Vision $** _____ **Total Monthly Premium $** _____

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.We do not discriminate in eligibility for coverage and benefits on the basis of sex, sexual orientation, gender, gender identity, race, religion, or national origin. We may differentiate on the basis of age in rating and age limits on coverage.

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty. Please consult your tax advisor.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

✍ _____ _____
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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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)

✍ **Initial premium amount** (based on age at application date)..... $ _____.__

1. Paper Check (submit signed check with application)..... ☐
2. Automatic Bank Account Withdrawal..... ☐

Ongoing Premium Payments (Select option #1a, #1b, or #2)

1. I want my payments automatically withdrawn from my bank
   a. Choose the day payments will be deducted every month from your bank account..... 1st through the 28th or the last day of every month

   OR

   b. Choose the week and weekday that payments will be deducted every month from your bank account..... **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
   (For Example: 3rd Wednesday of every month)

2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing)..... **every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND 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 placed inforce, 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(s) will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

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 begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

1. **Account Owner Name,** if different than applicant's..... _____
2. If premium is **NOT** paid by Proposed Insured/Insured **(includes spouse or joint-married account)**, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.

Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	☐
Living Trust	☐
Power of Attorney or legal guardian (documentation required)	☐
Business owned by applicant or applicant's spouse	☐

Part III. Muti-Policy Discount

You may be eligible for a lower premium rate based on your answer to the statement in this section

Are you applying for or have you applied for a Medicare supplement policy with Mutual of Omaha Insurance Company or its affiliates within the last 30 days?	☐ Y ☐ N
Do you have a Medicare supplement policy with Mutual of Omaha Insurance Company or one of its affiliates that has been issued within the last 30 days?.....	☐ Y ☐ N

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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

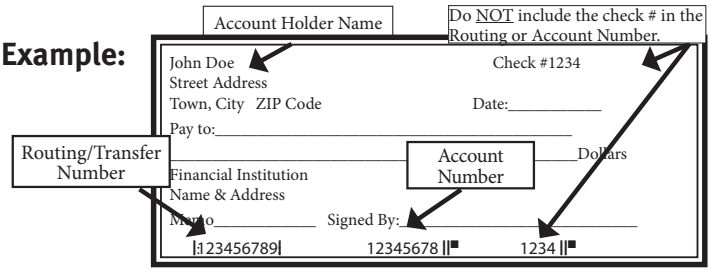
Routing Number (9 digits on lower left side of check)

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:



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

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NEW MEXICO CONFIDENTIAL ABUSE INFORMATION

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

Confidential abuse information may be received from persons other than a protected person. We, the insurer, are prohibited by law from using confidential abuse information as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

A protected person has the right to access and request correction, amendment or deletion of confidential abuse information. Please send such requests in writing.

For a full description of your rights please contact us at:

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

If you would like to be classified as a protected person and meet the following definition please sign the statement below and return it to our office.

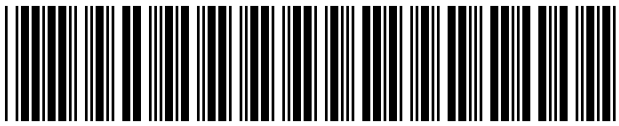
"Protected person" means a victim of domestic abuse who has notified an insurer that he or she is or has been a victim of domestic abuse or an individual or entity that provides shelter, advocacy, counseling, or protection to victims of domestic abuse.

I wish to be classified as a protected person.

_____
Applicant A Printed Name

_____ _____
Applicant A Signature Date

Policy/Certificate Number, if known: _____



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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.

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. 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 list of covered dental services with ADA codes, please visit our website at www.mutualofomaha.com/support/forms.

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**
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.

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 unless the covered person had coverage with a prior carrier;
(b) dental services or treatment which is experimental or investigational;
(c) dental 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;
(d) dental 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;
(e) dental services or treatment performed prior to the policy effective date;
(f) dental services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(g) dental services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(h) dental services or treatment resulting from your failure to comply with professionally prescribed treatment;
(i) telephone consultations;
(j) any charges for failure to keep a scheduled appointment;
(k) fluoride treatments;
(l) dental services or treatment provided as a result of intentionally self-inflicted injury or illness;
(m) dental 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;
(n) office infection control charges;
(o) 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;
(p) state, federal, or territorial taxes on dental services performed;
(q) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(r) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(s) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(t) those dental services which are for specialized procedures and techniques;
(u) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(v) duplicate, provisional and temporary devices, appliances, and services;
(w) 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;
(x) gold foil restorations;
(y) dental 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;
(z) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(aa) charges by the provider for completing dental forms;
(bb) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(cc) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(dd) sealants except for molar sealants, one treatment per tooth every five consecutive years as *dentally necessary*;
(ee) precision attachments, personalization, precious metal bases and other specialized techniques;
(ff) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(gg) repair of damaged orthodontic appliances;
(hh) replacement of lost or missing appliances;
(ii) nitrous oxide;

(jj) oral sedation;
(kk) topical medicament carrier;

(ll) bone grafts when done in connection with:
1. extractions;
2. apicoectomies or;
3. non-covered/non-eligible implants;

(mm) occlusal guards;
(nn) space maintainers;
(oo) dental services or treatment provided by a member of your immediate family; or
(pp) dental 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 at least 60 days advance written notice prior to any such premium change.

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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.

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. 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 list of covered dental services with ADA codes, please visit our website at www.mutualofomaha.com/support/forms.

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
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.

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 unless the covered person had coverage with a prior carrier;
(b) dental services or treatment which is experimental or investigational;
(c) dental 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;
(d) dental 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;
(e) dental services or treatment performed prior to the policy effective date;
(f) dental services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(g) dental services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(h) dental services or treatment resulting from your failure to comply with professionally prescribed treatment;
(i) telephone consultations;
(j) any charges for failure to keep a scheduled appointment;
(k) fluoride treatments;
(l) dental services or treatment provided as a result of intentionally self-inflicted injury or illness;
(m) dental 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;
(n) office infection control charges;
(o) 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;
(p) state, federal, or territorial taxes on dental services performed;
(q) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(r) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(s) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(t) those dental services which are for specialized procedures and techniques;
(u) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(v) duplicate, provisional and temporary devices, appliances, and services;
(w) 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;
(x) gold foil restorations;
(y) dental 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;
(z) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(aa) charges by the provider for completing dental forms;
(bb) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(cc) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(dd) sealants except for molar sealants, one treatment per tooth every five consecutive years as *dentally necessary*;
(ee) precision attachments, personalization, precious metal bases and other specialized techniques;
(ff) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(gg) repair of damaged orthodontic appliances;

(hh) replacement of lost or missing appliances;
(ii) nitrous oxide;
(jj) oral sedation;
(kk) topical medicament carrier;
(ll) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(mm) occlusal guards;
(nn) space maintainers;
(oo) dental services or treatment provided by a member of your immediate family; or
(pp) dental 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 at least 60 days advance written notice prior to any such premium change.