



Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

# APPLICATION for MEDICARE SUPPLEMENT INSURANCE AND DENTAL INSURANCE WITH OPTIONAL VISION RIDER

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# UNITED WORLD LIFE INSURANCE COMPANY

A Mutual of Omaha Company

## OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants											Medicare first eligible before 2020 only		
	PLAN A	PLAN B	PLAN D	PLAN G	G <sup>1</sup>	PLAN K	PLAN L	PLAN M	PLAN N	PLAN C	PLAN F	F <sup>1</sup>		
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply <sup>3</sup>	✓	✓		✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓		✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓		✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓		✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓		✓	
Medicare Part B deductible										✓	✓		✓	
Medicare Part B excess charges				✓							✓		✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓		✓	
Out-of-pocket limit in 2024 <sup>2</sup>						\$7,060 <sup>2</sup>	\$3,530 <sup>2</sup>			✓	✓		✓	

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible \$2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup>Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup>Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

**MONTHLY PREMIUMS\***  
**ZIP CODES: 932, 934-940, 950-953, 956-961**

NON-TOBACCO						TOBACCO					
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	
311.32	457.82	364.54		271.07	Thru 64	357.83	526.24	419.02		311.58	
124.53	183.13	145.82	48.94	108.43	65	143.14	210.49	167.60	56.25	124.64	
124.53	183.13	145.82	48.94	108.43	66	143.14	210.49	167.60	56.25	124.64	
136.98	201.45	160.40	48.94	119.27	67	157.45	231.55	184.37	56.25	137.10	
142.73	209.91	167.46	50.91	124.52	68	164.06	241.27	192.48	58.51	143.12	
148.49	218.37	174.52	52.86	129.77	69	170.68	251.00	200.60	60.76	149.16	
154.24	226.83	181.57	54.82	135.02	70	177.28	260.72	208.70	63.01	155.19	
159.99	235.29	188.63	56.77	140.26	71	183.90	270.44	216.82	65.25	161.22	
165.74	243.75	195.69	58.65	145.50	72	190.51	280.18	224.93	67.41	167.25	
172.71	253.98	203.91	60.56	151.62	73	198.52	291.93	234.38	69.61	174.28	
179.66	264.22	212.13	62.63	157.73	74	206.51	303.71	243.83	71.99	181.30	
186.64	274.46	220.34	64.69	163.84	75	214.52	315.47	253.27	74.36	188.33	
193.59	284.70	228.57	66.92	169.95	76	222.52	327.24	262.72	76.92	195.35	
200.55	294.93	236.79	69.15	176.07	77	230.52	339.00	272.17	79.48	202.38	
207.77	305.55	245.31	71.38	182.41	78	238.82	351.21	281.96	82.04	209.66	
214.99	316.17	253.83	73.57	188.74	79	247.11	363.41	291.75	84.56	216.95	
222.22	326.79	262.35	75.80	195.08	80	255.43	375.62	301.55	87.13	224.23	
229.44	337.40	270.87	78.13	201.42	81	263.72	387.82	311.35	89.80	231.51	
236.65	348.02	279.41	80.52	207.76	82	272.01	400.03	321.16	92.55	238.80	
245.17	360.55	289.46	82.97	214.82	83	281.81	414.43	332.72	95.36	246.92	
253.70	373.08	299.52	85.49	221.89	84	291.61	428.83	344.28	98.27	255.04	
262.21	385.61	309.58	88.10	228.96	85	301.39	443.23	355.84	101.27	263.17	
270.74	398.14	319.64	90.78	236.02	86	311.19	457.63	367.40	104.35	271.29	
279.25	410.67	329.69	93.54	243.08	87	320.98	472.04	378.96	107.52	279.40	
284.84	418.88	336.30	96.39	247.94	88	327.40	481.47	386.55	110.80	284.99	
290.53	427.25	343.02	99.32	252.89	89	333.94	491.10	394.27	114.16	290.68	
296.35	435.80	349.88	102.35	257.96	90	340.63	500.92	402.16	117.64	296.51	
302.26	444.51	356.88	105.46	263.11	91	347.43	510.94	410.20	121.22	302.43	
308.32	453.40	364.01	108.66	268.37	92	354.39	521.15	418.40	124.90	308.47	
314.49	462.48	371.30	111.97	273.74	93	361.48	531.59	426.78	128.70	314.64	
320.77	471.72	378.73	115.36	279.21	94	368.70	542.21	435.32	132.60	320.93	
327.19	481.16	386.29	118.87	284.80	95	376.08	553.06	444.01	136.63	327.36	
333.73	490.78	394.01	122.47	290.51	96	383.60	564.11	452.89	140.77	333.91	
340.41	500.60	401.90	126.18	296.31	97	391.28	575.40	461.95	145.04	340.59	
347.22	510.61	409.93	130.02	302.23	98	399.10	586.91	471.19	149.45	347.40	
354.16	520.82	418.14	133.95	308.28	99+	407.08	598.65	480.62	153.96	354.35	

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***

**ZIP CODES: 919-925, 930-931, 933, 941-943, 945, 947-949, 954-955**

NON-TOBACCO						TOBACCO					
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	
366.25	538.62	428.88		318.91	Thru 64	420.98	619.10	492.96		366.56	
146.51	215.45	171.55	57.58	127.57	65	168.40	247.64	197.18	66.18	146.63	
146.51	215.45	171.55	57.58	127.57	66	168.40	247.64	197.18	66.18	146.63	
161.15	237.00	188.70	57.58	140.32	67	185.23	272.41	216.90	66.18	161.29	
167.92	246.95	197.01	59.89	146.49	68	193.01	283.85	226.45	68.84	168.38	
174.70	256.90	205.32	62.19	152.67	69	200.80	295.29	236.00	71.48	175.48	
181.46	266.86	213.61	64.49	158.85	70	208.57	306.73	245.53	74.13	182.58	
188.22	276.81	221.92	66.79	165.01	71	216.35	318.17	255.08	76.77	189.67	
194.99	286.77	230.22	69.00	171.18	72	224.13	329.62	264.62	79.31	196.76	
203.19	298.80	239.89	71.24	178.38	73	233.55	343.45	275.74	81.89	205.03	
211.37	310.85	249.57	73.68	185.56	74	242.95	357.30	286.86	84.69	213.29	
219.57	322.89	259.23	76.11	192.76	75	252.38	371.14	297.96	87.48	221.56	
227.76	334.94	268.90	78.73	199.94	76	261.79	384.99	309.08	90.49	229.82	
235.94	346.97	278.57	81.35	207.14	77	271.20	398.82	320.20	93.51	238.09	
244.44	359.48	288.60	83.97	214.59	78	280.96	413.19	331.72	96.52	246.66	
252.93	371.96	298.62	86.55	222.05	79	290.72	427.54	343.24	99.48	255.23	
261.44	384.45	308.65	89.18	229.51	80	300.50	441.90	354.77	102.50	263.80	
269.93	396.95	318.67	91.92	236.96	81	310.26	456.26	366.29	105.65	272.37	
278.41	409.44	328.71	94.73	244.42	82	320.01	470.62	377.83	108.88	280.94	
288.44	424.18	340.54	97.61	252.73	83	331.54	487.56	391.43	112.19	290.49	
298.47	438.92	352.38	100.58	261.04	84	343.07	504.50	405.03	115.61	300.05	
308.49	453.66	364.22	103.65	269.36	85	354.58	521.45	418.64	119.14	309.61	
318.52	468.40	376.05	106.80	277.67	86	366.11	538.39	432.24	122.76	319.16	
328.53	483.15	387.87	110.05	285.98	87	377.62	555.34	445.83	126.49	328.71	
335.11	492.80	395.64	113.40	291.69	88	385.18	566.44	454.76	130.35	335.28	
341.80	502.65	403.55	116.85	297.52	89	392.87	577.76	463.85	134.31	341.98	
348.64	512.71	411.62	120.41	303.48	90	400.74	589.32	473.13	138.40	348.83	
355.60	522.96	419.85	124.07	309.55	91	408.74	601.10	482.59	142.61	355.80	
362.73	533.41	428.25	127.84	315.73	92	416.93	613.12	492.24	146.94	362.91	
369.99	544.10	436.82	131.73	322.05	93	425.27	625.40	502.09	151.41	370.17	
377.38	554.96	445.56	135.72	328.49	94	433.77	637.89	512.14	156.00	377.57	
384.93	566.07	454.46	139.84	335.06	95	442.45	650.66	522.37	160.74	385.13	
392.62	577.38	463.55	144.08	341.77	96	451.29	663.66	532.81	165.61	392.84	
400.49	588.94	472.82	148.45	348.60	97	460.33	676.94	543.47	170.63	400.69	
408.49	600.72	482.28	152.96	355.57	98	469.53	690.48	554.34	175.82	408.70	
416.66	612.73	491.92	157.58	362.69	99+	478.92	704.29	565.43	181.13	416.88	

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***  
**ZIP CODES: 900-918, 926-928, 944, 946**

NON-TOBACCO						TOBACCO					
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age Thru 64	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	
399.22	587.09	467.47		347.61	64	458.87	674.82	537.33		399.55	
159.69	234.84	186.99	62.76	139.05	65	183.56	269.93	214.93	72.14	159.83	
159.69	234.84	186.99	62.76	139.05	66	183.56	269.93	214.93	72.14	159.83	
175.65	258.33	205.69	62.76	152.95	67	201.90	296.93	236.42	72.14	175.81	
183.03	269.18	214.74	65.28	159.68	68	210.38	309.40	246.83	75.04	183.53	
190.42	280.02	223.80	67.79	166.41	69	218.87	321.87	257.24	77.91	191.27	
197.79	290.87	232.84	70.30	173.14	70	227.34	334.34	267.63	80.80	199.01	
205.17	301.72	241.89	72.80	179.86	71	235.82	346.81	278.04	83.68	206.74	
212.54	312.58	250.94	75.21	186.59	72	244.30	359.29	288.44	86.45	214.47	
221.48	325.69	261.48	77.66	194.43	73	254.57	374.36	300.56	89.26	223.48	
230.39	338.83	272.03	80.31	202.26	74	264.82	389.46	312.68	92.31	232.49	
239.33	351.95	282.56	82.96	210.11	75	275.09	404.54	324.78	95.35	241.50	
248.26	365.09	293.10	85.81	217.94	76	285.35	419.64	336.90	98.63	250.50	
257.18	378.20	303.65	88.68	225.78	77	295.61	434.71	349.02	101.93	259.52	
266.44	391.83	314.57	91.53	233.91	78	306.25	450.38	361.58	105.21	268.86	
275.69	405.44	325.49	94.34	242.04	79	316.89	466.02	374.13	108.43	278.20	
284.96	419.05	336.43	97.20	250.16	80	327.55	481.67	386.70	111.73	287.54	
294.22	432.67	347.35	100.19	258.29	81	338.18	497.32	399.26	115.16	296.88	
303.47	446.29	358.30	103.25	266.42	82	348.81	512.98	411.84	118.68	306.23	
314.40	462.35	371.19	106.39	275.47	83	361.38	531.44	426.66	122.29	316.63	
325.33	478.42	384.09	109.63	284.54	84	373.95	549.91	441.48	126.02	327.05	
336.25	494.49	397.00	112.98	293.60	85	386.49	568.38	456.32	129.86	337.48	
347.18	510.56	409.89	116.41	302.66	86	399.06	586.85	471.14	133.81	347.88	
358.10	526.63	422.78	119.95	311.72	87	411.61	605.32	485.96	137.87	358.29	
365.27	537.16	431.25	123.61	317.95	88	419.85	617.42	495.69	142.08	365.46	
372.56	547.89	439.87	127.37	324.30	89	428.23	629.76	505.60	146.40	372.76	
380.02	558.85	448.67	131.24	330.80	90	436.81	642.36	515.71	150.86	380.23	
387.61	570.02	457.64	135.24	337.41	91	445.53	655.20	526.02	155.45	387.82	
395.37	581.42	466.79	139.34	344.15	92	454.45	668.30	536.54	160.17	395.57	
403.28	593.07	476.13	143.58	351.03	93	463.54	681.69	547.28	165.04	403.49	
411.34	604.91	485.66	147.94	358.05	94	472.81	695.30	558.23	170.04	411.55	
419.58	617.02	495.36	152.43	365.22	95	482.27	709.22	569.38	175.21	419.79	
427.96	629.35	505.26	157.05	372.53	96	491.91	723.39	580.76	180.52	428.20	
436.53	641.94	515.37	161.81	379.98	97	501.76	737.87	592.38	185.99	436.75	
445.26	654.78	525.68	166.73	387.57	98	511.79	752.62	604.23	191.64	445.48	
454.16	667.88	536.20	171.77	395.33	99+	522.02	767.68	616.32	197.43	454.40	

\*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.



### **Premium Information**

The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies of this form issued in the same state to persons of the same classification.

Use this outline to compare benefits and premiums among policies.

### **Read Your Policy Very Carefully**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### **Thirty Day Right to Return Policy**

If you find that you are not satisfied with your policy, you may return it to 3300 Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

### **Policy Replacement**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **Household Premium Discount**

You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

### **Disclosures**

The policy may not fully cover all of your medical costs. Neither United World Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for referral to your local HICAP office. HICAP is a service provided free of charge by the State of California. You may also contact the Consumer Affairs department of the California Department of Insurance after first contacting your agent or the insurance company for resolution of any problems. Mutual of Omaha's toll-free customer service telephone number is shown on the face page of your policy. You can contact the Consumer Affairs department at California Department of Insurance, Consumer Service Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP(4357).

### **Notice**

The policy may not fully cover all of your medical costs. United World Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

### **Complete Answers Are Very Important**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

### **Exclusions**

Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not cover Part A benefits for benefit periods that begin while this policy is not in force, and other exclusions apply.

**PLAN A**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but \$1,632	\$0	\$1,632 (Part A deductible)
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$408 a day	\$408 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$204 a day	\$0	Up to \$204 a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.



**PLAN A**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN A PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLAN F**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

**Medicare first eligible before 2020 only**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$408 a day	\$408 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$204 a day	Up to \$204 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**  
Medicare first eligible before 2020 only

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$240 of Medicare-approved amounts*	\$0	\$240 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLAN F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**  
Medicare first eligible before 2020 only

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit

**PLAN G  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days			
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$1,632	\$1,632 (Part A deductible)	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$408 a day	\$408 a day	\$0
Once lifetime reserve days are used: Additional 365 days	All but \$816 a day	\$816 a day	\$0
Beyond the additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days			
21 <sup>st</sup> through 100 <sup>th</sup> day	All approved amounts	\$0	\$0
101 <sup>st</sup> day and after	All but \$204 a day	Up to \$204 a day	\$0
	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b>			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0



**PLAN G**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

<b>OTHER BENEFITS – NOT COVERED BY MEDICARE</b>		<b>PLAN G PAYS</b>		<b>YOU PAY</b>
<b>SERVICES</b>	<b>MEDICARE PAYS</b>			
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0		\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000		20% and amounts over the \$50,000 lifetime maximum benefit

## HIGH DEDUCTIBLE PLAN G

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE*** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days			
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$1,632	\$1,632 (Part A deductible)	\$0
91 <sup>st</sup> day and after:			
While using 60 lifetime reserve days	All but \$408 a day	\$408 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	All but \$816 a day	\$816 a day	\$0
Beyond the additional 365 days			
	\$0	100% of Medicare-eligible expenses	\$0**
	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days			
21 <sup>st</sup> through 100 <sup>th</sup> day	All approved amounts	\$0	\$0
101 <sup>st</sup> day and after	All but \$204 a day	Up to \$204 a day	\$0
	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## HIGH DEDUCTIBLE PLAN G

### MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

\*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE*** YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

### PARTS A AND B

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0

# **HIGH DEDUCTIBLE PLAN G** **MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*\*\*This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

## **OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2,800 DEDUCTIBLE*** PLAN PAYS</b>	<b>IN ADDITION TO \$2,800 DEDUCTIBLE*** YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum benefit

**PLAN N**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days			
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$1,632	\$1,632 (Part A deductible)	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$408 a day	\$408 a day	\$0
Once lifetime reserve days are used: Additional 365 days	All but \$816 a day	\$816 a day	\$0
Beyond the additional 365 days	\$0	100% of Medicare-eligible expenses	\$0**
	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days			
21 <sup>st</sup> through 100 <sup>th</sup> day	All approved amounts	\$0	\$0
101 <sup>st</sup> day and after	All but \$204 a day	Up to \$204 a day	\$0
	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0



**PLAN N**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

**PARTS A AND B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN N PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<b>DURABLE MEDICAL EQUIPMENT</b> First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN N PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum benefit



Producer Name

Agent Writing Number  
or Social Security Number

Commission Share

Commission Code

Required only if you are not  
appointed or licensed or are  
changing brokerage firms

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**Preferred Method of Communication (Select one)**☐ Phone ☐ Fax ☐ Email Contact info: \_\_\_\_\_

**Note:** Producers must be under the same commission code to share or split commissions. Please update your contact information at <http://www.mutualofmaha.com/>.

**Application Submission Checklist - United World Life Ins Co. Medicare Supplement Coverage**☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**☐ **Provide Applicant with the Outline of Coverage**

- Calculate the premium based on age at application date

☐ **Complete the Calculate Your Premium form to determine rate**☐ **Application (complete in full)****Sections A & B: Plan and Applicant Information**

- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

**Section C: Medicare Information**

- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

**Section D: Household Premium Discount Information**

- Indicate if eligible for a Household Premium Discount

**Section E: Previous or Existing Coverage Information**

- Please complete ALL questions in full

**For Sections F and G - Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.**

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

- If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F, they can skip to Section I

**Sections G & H: Health/Medication Information**

- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

**Section I: Agreement and Authorization**

- Make sure applicant(s) sign and date the application

**Section K: To be Completed by Producer**

- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**

- Use premium determined by the **Calculate Your Premium form**
- One month's premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices**☐ **Complete Senior 24-hour meeting Notice and leave with the applicant**

**Note:** An interviewer may call to verify/confirm the information provided on the application.  
This form is required if splitting commissions.



Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

## Calculate Your Premium

**PLEASE COMPLETE**

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

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

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	<b>Age</b> Write in your age at the time of signing the application. <b>ZIP Code</b> Indicate your ZIP Code used to determine your rate.	65  51502		
#2	<b>Premium</b> Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	<b>Household Premium Discount</b> Please refer to the application for state specific household premium discount rules.  <b>If the rules apply</b> , multiply the amount from Step #2 by .88. <b>If the rules do not apply</b> , enter the amount from Step #2.	$\$128.52 \times .88 =$ \$113.10  In this example, the person qualifies for the household premium discount.		
#4	<b>Payment Options</b> Your monthly payment is your last premium entered (Step #2 or #3).  To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$113.10 monthly payment  \$339.30 quarterly payment \$678.6 semiannual payment \$1,357.20 annual payment		



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## Height and Weight Chart

### Eligibility

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

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	55 - 145	146 +
4' 3"	< 56	57 - 151	152 +
4' 4"	< 58	59 - 157	158 +
4' 5"	< 60	61 - 163	164 +
4' 6"	< 63	64 - 170	171 +
4' 7"	< 65	66 - 176	177 +
4' 8"	< 67	68 - 182	183 +
4' 9"	< 70	71 - 189	190 +
4' 10"	< 72	73 - 196	197 +
4' 11"	< 75	76 - 202	203 +
5' 0"	< 77	78 - 209	210 +
5' 1"	< 80	81 - 216	217 +
5' 2"	< 83	84 - 224	225 +
5' 3"	< 85	86 - 231	232 +
5' 4"	< 88	89 - 238	239 +
5' 5"	< 91	92 - 246	247 +
5' 6"	< 93	94 - 254	255 +
5' 7"	< 96	97 - 261	262 +
5' 8"	< 99	100 - 269	270 +
5' 9"	< 102	103 - 277	278 +
5' 10"	< 105	106 - 285	286 +
5' 11"	< 108	109 - 293	294 +
6' 0"	< 111	112 - 302	303 +
6' 1"	< 114	115 - 310	311 +
6' 2"	< 117	118 - 319	320 +
6' 3"	< 121	122 - 328	329 +
6' 4"	< 124	125 - 336	337 +
6' 5"	< 127	128 - 345	346 +
6' 6"	< 130	131 - 354	355 +
6' 7"	< 134	135 - 363	364 +
6' 8"	< 137	138 - 373	374 +
6' 9"	< 140	141 - 382	383 +
6' 10"	< 144	145 - 392	393 +
6' 11"	< 147	148 - 401	402 +
7' 0"	< 151	152 - 411	412 +
7' 1"	< 155	156 - 421	422 +
7' 2"	< 158	159 - 431	432 +
7' 3"	< 162	163 - 441	442 +
7' 4"	< 166	167 - 451	452 +

Medicare supplement insurance is underwritten by

**UNITED WORLD LIFE INSURANCE COMPANY**

3300 Mutual of Omaha Plaza

Omaha, Nebraska 68175

[mutualofomaha.com](http://mutualofomaha.com)



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Agent Writing #

DNIS

Auth #

Group # (if applicable)

Keyline



Mutual of Omaha

Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3316 Farnam Street  
Omaha, Nebraska 68175

## Application for Medicare Supplement Coverage

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

### How Did You Hear About Us?



Please select all that apply. Thank you for providing this helpful information.

- ☐ Agent/Broker/Producer
- ☐ Family Member/Friend
- ☐ Physician Referral
- ☐ Social Media
- ☐ Direct Mail
- ☐ Internet Search
- ☐ Radio
- ☐ TV

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

Applicant A	Applicant B
<div>Plan (select one):<div><input type="checkbox"/> Plan A<input type="checkbox"/> Plan G<input type="checkbox"/> High Deductible Plan G<input type="checkbox"/> Plan N</div><div>OR</div><div>If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option:<div><input type="checkbox"/> Plan F</div></div></div>	<div>Plan (select one):<div><input type="checkbox"/> Plan A<input type="checkbox"/> Plan G<input type="checkbox"/> High Deductible Plan G<input type="checkbox"/> Plan N</div><div>OR</div><div>If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option:<div><input type="checkbox"/> Plan F</div></div></div>
Requested Effective Date	Requested Effective Date
Deliver Policy to: <div>Applicant A <input type="checkbox"/> Producer <input type="checkbox"/></div>	Deliver Policy to: <div>Applicant B <input type="checkbox"/> Producer <input type="checkbox"/></div>

## B. Applicant Information (Must be completed in ink!)

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
City	City
StateZIP	StateZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
StateZIP	StateZIP
Home Phone (area code)	Home Phone (area code)
E-mail Address	E-mail Address
Current Age	Current Age
Date of Birthmo day yr	Date of Birthmo day yr

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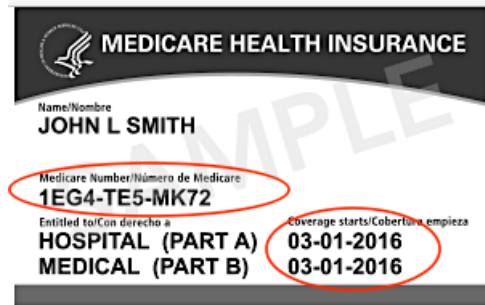


## B. Applicant Information (Continued)

Applicant A	Applicant B
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	Social Security # <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ..... <input type="checkbox"/> Y <input type="checkbox"/> N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ..... <input type="checkbox"/> Y <input type="checkbox"/> N

## C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	Medicare Part A Effective Date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>
If you are not covered under Medicare Part A, what is your eligibility date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	If you are not covered under Medicare Part A, what is your eligibility date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>
Medicare Part B Effective Date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	Medicare Part B Effective Date <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>	If you are not covered under Medicare Part B, indicate the date you plan to enroll <span style="border-bottom: 1px solid black; display: inline-block; width: 100px;"></span>

## D. Household Premium Discount Information

	Applicant A	Applicant B
<b>You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.</b>		
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months and who is age 60 or older; or (b) with whom you reside and to whom you are either married or have a declaration of Domestic Partnership filed at the Secretary of State? .....		
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.		
Name (First/Middle/Last)		
Date of Birth		
Street Address		
City/State/ZIP		

## E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:

3. Are you covered for medical assistance through the state Medicaid or Medi-Cal program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)

**If "YES," answer the following about this existing coverage:**

- (a) Will Medicaid or Medi-Cal pay your premiums for this Medicare supplement policy?...
- (b) Do you receive any benefits from Medicaid or Medi-Cal OTHER THAN payments toward your Medicare Part B premium?.....

**Applicant A**

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

**Applicant B**

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

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

4. Do you have another Medicare supplement or or health service plan in force? .....

**If "YES," answer the following about this existing coverage:**

- (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

(b) Indicate planned termination or disenrollment date..... Applicant A

Applicant B

(c) With what company, and what plan do you have?

#### Applicant A

Name of Company

Plan

Effective Date

#### Applicant B

Name of Company

Plan

Effective Date

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

5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)...

☐ Y ☐ N

☐ Y ☐ N

**If "YES," answer the following about this previous or existing coverage:**

- (a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....

Applicant A START

END

Applicant B START

END

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....

☐ Y ☐ N

☐ Y ☐ N

(c) Planned date of termination/disenrollment?.....

Applicant A

Applicant B

(d) Was this your first time in this type of Medicare plan? .....

☐ Y ☐ N

☐ Y ☐ N

(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan? .....

☐ Y ☐ N

☐ Y ☐ N

(f) Is your former Medicare supplement or Medicare Select policy/certificate still available?

☐ Y ☐ N

☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:

- Your Medicare Advantage plan is leaving the Medicare program.....
- Your Medicare Advantage organization stopped offering Medicare Advantage plans..
- Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
- You moved out of the geographic service area of your Medicare Advantage plan.....
- You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....

■ Other: \_\_\_\_\_

Applicant A

Applicant B

Check box(s) below if applicable

Applicant A

☐  
☐  
☐  
☐  
☐

Applicant B

☐  
☐  
☐  
☐  
☐

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

6. Have you had coverage under any other health insurance within the past 63 days?.....  
(For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)

Applicant A

☐ Y ☐ N

Applicant B

☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?

If you are still covered under this plan, leave "END" blank..... Applicant A START

END



Applicant B START

END

(b) Planned date of termination/disenrollment?..... Applicant A

Applicant B

(c) Have you disenrolled from your current coverage voluntarily?..... ☐ Y ☐ N ☐ Y ☐ N

(d) Please state the reason for your disenrollment:

Applicant A

Applicant B

(e) With what company and what kind of policy/certificate? (List below.)

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

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

To the Best of Your Knowledge and Belief:

7. Are you applying during an open enrollment period?

(a) Did you turn age 65 in the last six months?.....

(b) Did you enroll in Medicare Part B in the last six months?.....

Applicant A

☐ Y ☐ N  
☐ Y ☐ N

Applicant B

☐ Y ☐ N  
☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A

Applicant B

8. Are you applying during a guaranteed issue period?.....

(NOTE: Refer to Section J of this application to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)

☐ Y ☐ N

☐ Y ☐ N

**STOP** IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

(NOTE: Refer to Section J of this application to help identify if you are eligible)

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

[(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)]

## G. Health Information



For all plans, answer questions 9-19 with Yes (Y), No (N), or Not Sure (NS).

**Part A: Medical Questions:** (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
11. Within the past five years, have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alzheimer's disease, dementia or any other cognitive disorder? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Systemic lupus, scleroderma or myasthenia gravis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. Chronic hepatitis or cirrhosis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
<b>California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</b>		
12. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
13. Do you have Osteoporosis, and as a result, experienced a fracture? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
14. Within the past five years have you been treated for diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
15. Do you have an implanted cardiac defibrillator? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS

**Part B: Medical Questions:** (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
C. Alcoholism or drug abuse? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
D. Any mental or nervous disorder requiring treatment (including hospital confinement)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
E. Internal cancer, lymphoma or melanoma? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
F. A stroke or transient ischemic attack (TIA)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
17. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
B. Had any changes in your medications within the past two years? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
18. Have you been hospital confined three or more times in the past two years for a same or similar condition? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS
19. Within the past two years, have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? .....	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NS

**NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.**

G. Health Information (cont.)

20. Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? .....  
(If answered "No" you will be eligible for a discount on your premium)

Applicant A  
☐ Y ☐ N ☐ NS

Applicant B  
☐ Y ☐ N ☐ NS

21. Applicant A (Height) Ft   In   (Weight) Lbs    ☐ NS

Applicant B (Height) Ft   In   (Weight) Lbs    ☐ NS

H. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years. If you are unsure of the answer, do not know how to respond, or do not understand the question you may select "Not Sure" or "NS" or state "Not Sure" or "NS" in the space provided..

To the Best of Your Knowledge and Belief:  
22. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications? .....

Applicant A  
☐ Y ☐ N ☐ NS

Applicant B  
☐ Y ☐ N ☐ NS

Applicant A

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

Applicant B

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

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# I. Agreement and Authorization

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## IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid or Medi-Cal and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid or Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid or Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid or Medi-Cal. If you are no longer entitled to Medicaid or Medi-Cal, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid or Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free number (1-800-927-HELP), your local HICAP office, or by accessing the Department of Insurance's internet website ([www.insurance.ca.gov](http://www.insurance.ca.gov)).
- **CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**




# I. Agreement and Authorization (cont.)


## AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED WORLD LIFE INSURANCE COMPANY

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

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

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

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

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





## J. Guaranteed Issue and Open Enrollment

### Eligibility for Guaranteed Issue

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

- ☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits or the Medicare Part B 20% coinsurance for services to the individual.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.
- ☐ Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.
- ☐ Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and the plan reduces any of its benefits or increases the amount of cost sharing or premium or discontinues (for other than good cause relating to the quality of care) its relationship or contract under the plan with a provider who is currently furnishing services to the individual.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by the same insurance company, a subsidiary of the same parent company, or a network that contracts with the insurance company's parent company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by the same insurance company, a subsidiary of the same parent company, or a network that contracts with the insurance company's parent company.
- ☐ Enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, or similar organization and premiums or copayments increase by 15% or more, benefits are reduced, or the provider contract is terminated with the medical provider treating the individual.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.
- ☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, material misrepresentation, or other involuntary termination of coverage.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.
- ☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment.

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.
- ☐ Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.
  - If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.
  - If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.





## J. Guaranteed Issue and Open Enrollment (Cont.)

### Eligibility for Guaranteed Issue (Cont.)

- ☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy.
  - *If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K, L, M, or N that is sold in the applicant's state by any insurance company.*
  - *If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K, L, M or N that is sold in the applicant's state by any insurance company.*

**Documentation of these events must be submitted with this Application. You must also apply within 63 days of the date of termination or the date you are notified of termination of previous coverage in order to qualify as an eligible person.**

### Eligibility for Open Enrollment

The following are requirements for individuals who are eligible for open enrollment:

- ☐ **Age 65 or over**

If you are age 65 or over and eligible for Medicare, you have a six month period during which you can purchase any Medicare supplement policy available from any insurer at the lowest price for your age, even if you have or recently had health problems. Your six month open enrollment period starts the date your Medicare Part B coverage becomes effective. To avoid a gap in coverage you can apply for a Medicare supplement policy before the effective date of your Part B coverage and request that the policy begin on the same day as your Medicare benefits.
- ☐ **Under Age 65**

If you are younger than age 65 and have Medicare because of a disability (not End-Stage Renal Disease), you have open enrollment rights for six months after the effective date of your Medicare Part B coverage. If you are notified retroactively of your eligibility for Medicare, your open enrollment period begins from the date of the notice of eligibility. To avoid a gap in coverage, you may request that the Medicare supplement policy becomes effective on the same day as your Medicare benefits.

  - *If Medicare Part A eligibility date is before 01/01/2020, you have the right to purchase Plans A, B, C, F, High Deductible Plan F, or N if currently available.*
  - *If Medicare Part A eligibility date is on or after 01/01/2020, you have the right to purchase Plans A, B, D, G, High Deductible Plan G, or N if currently available.*

If you became eligible for Medicare when you were younger than 65, you are also entitled to a six month open enrollment period on your 65th birthday, regardless of any health condition you may have, including End Stage Renal Disease. If you already have a Medicare supplement policy, you can keep it and request a lower premium because you are age 65, or you can switch to another Medicare supplement policy that better suits your needs. At age 65 you have the right to purchase any Medicare supplement policy available from any company.

#### **Additional Open enrollment rights**

- ☐ An individual enrolled in Medicare Part B is entitled to the described open enrollment for six months following:
  - Receipt of a notice of termination or, if no notice is received, the effective date of termination from an employer sponsored health plan including an employer sponsored retiree health plan.
  - Receipt of a notice of loss of eligibility due to the divorce or death of a spouse, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse from any employer-sponsored health plan including an employer sponsored retiree health plan.
  - Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.
  - An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan
  - An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, they only meet one of the following requirements: (1) they are no longer eligible for Medi-Cal benefits, or (2) they are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

#### **If you are Under 65:**

- *If Medicare Part A eligibility date is before 01/01/2020, you have the right to purchase Plans A, B, C, F, High Deductible Plan F, or N if currently available.*
- *If Medicare Part A eligibility date is on or after 01/01/2020, you have the right to purchase Plans A, B, D, G, High Deductible Plan G, or N if currently available.*

**If you are Over 65** you can purchase any plan available. Plans C, F, and High Deductible F are available only if your Medicare Part A eligibility date is before 01/01/2020.

- ☐ An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.
- ☐ An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.



## K. To be Completed by Producer

23. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).

(a) List policies/certificates sold to the applicant(s) which are still in force.

<b>Applicant A</b>
<b>Applicant B</b>

(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.

<b>Applicant A</b>
<b>Applicant B</b>

### I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant(s)..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant(s)..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. \_\_\_\_\_

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

To the best of my knowledge, the information in the application is complete and accurate.

I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

I willfully state as true, any material fact I know to be false, that I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars.



Signature of Licensed Producer

Date



Signature of Licensed Producer

Date

Printed Name

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

Agent Writing Number

Printed Name

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

Agent Writing Number



**This fraud warning endorsement is added to your application.**

**If your application already contains a fraud warning such fraud warning is removed and replaced by the statement below.**


**Fraud Warning:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



# METHOD OF PAYMENT FORM

REQUIRED FORM - PLEASE RETURN PAGES 1 & 2

## Part I. Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)	Applicant A	Applicant B
<p> <b>Initial premium amount</b> (based on age at application date)..... \$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>1. Paper Check (submit signed check with application)..... <input type="checkbox"/></p> <p>(California collect only one month's premium at time of application)</p> <p>2. Automatic Bank Account Withdrawal..... <input type="checkbox"/></p>	<p>1<sup>st</sup> through the 28<sup>th</sup> or the last day of every month</p> <p>Week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>	<p>1<sup>st</sup> through the 28<sup>th</sup> or the last day of every month</p> <p>Week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>
<p><b>Ongoing Premium Payments (Select option #1a, #1b, or #2)</b></p> <p>1. I want my payments automatically withdrawn from my bank</p> <p>a. Choose the day payments will be deducted every month from your bank account.....</p> <p style="text-align: center;">OR</p> <p>b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)</p>	<p>every _____ months Insert 3, 6, or 12</p>	<p>every _____ months Insert 3, 6, or 12</p>
<p>2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....</p>		

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 in force, 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

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



Part III. Account Information

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

Can attach voided check here

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

Applicant B

☐ Same account as 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

Street Address

Town, City ZIP Code

Pay to:

Date:

Check #1234

Routing/Transfer Number

Financial Institution Name & Address

Account Number

Dollars

Memo

Signed By

123456789

12345678

1234

I authorize United World Life Insurance Company ("United World") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. This authorization shall apply to any future payments unless specifically revoked by me. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United World 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, United World may require written confirmation from me within 14 days after my verbal notice.

Applicant A

Authorized Signature as Shown on Account

Date

Applicant B

Authorized Signature as Shown on Account

Date





Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

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

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

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by United World Life Insurance Company, please review the new coverage carefully and replace the existing coverage **ONLY** if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

### Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this this replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

#### Applicant A

Additional benefits that are: \_\_\_\_\_

- \_\_\_\_\_ No change in benefits, but lower premiums
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- \_\_\_\_\_ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
- \_\_\_\_\_ Other reasons specified here: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Applicant B

Additional benefits that are: \_\_\_\_\_

- \_\_\_\_\_ No change in benefits, but lower premiums
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- \_\_\_\_\_ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
- \_\_\_\_\_ Other reasons specified here: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**DO NOT CANCEL YOUR PRESENT POLICY OR CERTIFICATE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**



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

\_\_\_\_\_  
**Date**

United World Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

#### Applicant A

Signature



Date

#### Applicant B

Signature



Date

\*Signature not required for direct response sales.



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## IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

**Replacement Notice**

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

**Guaranteed Issue and Open Enrollment Notice****24-Hour Meeting Notice****Premium Receipt / Notice of Information Practices**



Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

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#### Applicant A

Additional benefits that are: \_\_\_\_\_

- \_\_\_\_\_ No change in benefits, but lower premiums
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- \_\_\_\_\_ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
- \_\_\_\_\_ Other reasons specified here: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Applicant B

Additional benefits that are: \_\_\_\_\_

- \_\_\_\_\_ No change in benefits, but lower premiums
- \_\_\_\_\_ Fewer benefits and lower premiums
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- \_\_\_\_\_ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
- \_\_\_\_\_ Other reasons specified here: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**DO NOT CANCEL YOUR PRESENT POLICY OR CERTIFICATE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**



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

\_\_\_\_\_  
**Date**

United World Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

#### Applicant A

Signature



Date

#### Applicant B

Signature



Date

\*Signature not required for direct response sales.



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Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

Dear \_\_\_\_\_

Thank you for agreeing to meet with me on \_\_\_\_\_  
Date Time

During this meeting, or a follow-up meeting, we will be discussing the following:

A sales presentation on:

☐ Life insurance

☐ Annuities

☐ OTHER insurance \_\_\_\_\_

In Addition:

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

You have the right to contact the Department of Insurance for information, or to file a complaint at 1-800-927-4357.

The following individuals will be coming to your home:

\_\_\_\_\_  
Name License #

\_\_\_\_\_  
Name License #

Sincerely,

United World Life Insurance Company Representative



Health Insurance Underwritten by United World Life Insurance Company and Mutual of Omaha Insurance Company

Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company

Located at 3300 Mutual of Omaha Plaza, Omaha NE, 68175

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W468683\_CA



Underwritten by  
United World Life Insurance Company  
A Mutual of Omaha Company

3316 Farnam Street  
Omaha, Nebraska 68175

## Premium Receipt

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

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

### Applicant A

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

### Applicant B

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

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



## Notice of Information Practices

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

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

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

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

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED WORLD LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, 3316 FARNAM STREET, OMAHA, NE 68175.**

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

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Underwritten by  
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

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

**CALIFORNIA**



Underwritten by  
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

CALIFORNIA							
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	
922-924,932,933, 936,937,952,953	\$61.46	\$70.38	\$73.45	\$33.69	\$34.64	\$35.28	\$8.28
925,934,935,954, 955,959-961	\$64.11	\$73.41	\$76.62	\$35.14	\$36.13	\$36.80	\$8.28
900-903,905-921, 926-931,939,940, 945-951,956-958	\$66.76	\$76.44	\$79.78	\$36.59	\$37.62	\$38.32	\$8.28
904, 938, 941-944	\$69.40	\$79.48	\$82.95	\$38.04	\$39.12	\$39.84	\$8.28

Rates Subject to Change.

As of 07/14/2023

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)



Underwritten by  
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

Internal Tracking Code \_\_\_\_\_  
Group # (if applicable) \_\_\_\_\_

## 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 _____	

### B. Plan Information

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

### C. Existing Coverage Information

Are you covered by any other dental or vision insurance? .....	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If Yes, answer the following about this existing coverage:</b>	
Name of dental carrier(s) _____	
Name of vision carrier(s) _____	
Is the coverage you are applying for replacing existing dental insurance? .....	<input type="checkbox"/> Y <input type="checkbox"/> N
Is the coverage you are applying for replacing existing vision insurance? .....	<input type="checkbox"/> Y <input type="checkbox"/> N

### D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. 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 \_\_\_\_\_%

**This fraud warning endorsement is added to your application.**

**If your application already contains a fraud warning such fraud warning is removed and replaced by the statement below.**

**Fraud Warning:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



# 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.....

1<sup>st</sup> through the 28<sup>th</sup> 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.....  
(For Example: 3rd Wednesday of every month)

Week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, last)

Weekday (Mon, Tue, Wed,  
Thu, Fri) \_\_\_\_\_

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 in force, 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



**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)

- 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 <u>NOT</u> include the check # in the Routing or Account Number.	
John Doe		Check #1234	
Street Address		Date: _____	
Town, City ZIP Code			
Pay to: _____		Dollars	
Routing/Transfer Number	Financial Institution Name & Address	Account Number	
	Memo to _____	Signed By: _____	
	123456789	12345678	1234

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.**

**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](http://www.mutualofomaha.com/individual-dental).

**DENTAL BENEFITS SUMMARY**

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

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 paid for by worker's compensation or third party liability coverage;
- (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
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

**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.

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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 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 a [www.mutualofomaha.com/individual-dental](http://www.mutualofomaha.com/individual-dental).

**DENTAL BENEFITS SUMMARY**

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

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 paid for by worker's compensation or third party liability coverage;
- (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
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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