Agent Writing # _____ FAV Key_____ Auth # _____

Group # (if applicable)_____ Keyline _____

Mutual of Omaha

Underwritten by
Omaha Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
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
Plan (select one): ☐ Plan A ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: ☐ Plan F ☐ Plan F - High Deductible	Plan (select one): ☐ Plan A ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: ☐ Plan F ☐ Plan F - High Deductible
Requested Effective Date ___ / ___ / _____	**Requested Effective Date** ___ / ___ / _____
Deliver Policy to Applicant A ☐ Producer ☐	**Deliver Policy to** Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP _____	State ZIP _____
Home Phone ___ – ___ – _____ (area code)	Home Phone ___ – ___ – _____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ___ / ___ / _____ (mo / day / yr)	Current Age _____ Date of Birth ___ / ___ / _____ (mo / day / yr)
☐ Male ☐ Female	☐ Male ☐ Female

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B. Applicant Information

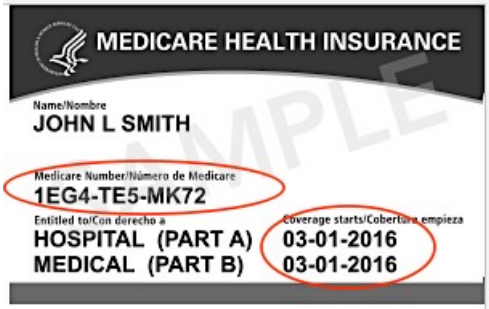
Applicant A	Applicant B
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___
Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N	Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N

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

Receive statement online? ☐ Y ☐ N	Receive statement online? ☐ Y ☐ 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 ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____	Medicare Part A Effective Date ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____
Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____	Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant 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 in a civil union partnership?..	☐ Y ☐ N	☐ Y ☐ 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, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N
Please answer questions regarding another Medicare supplement or Select plan:		
4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
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
(b) Indicate planned termination or disenrollment date. .....Applicant A	__/__/____	
Applicant B	__/__/____	

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

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

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):	Applicant A	Applicant B
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:	Check box(s) below if applicable Applicant A	Applicant B
■ 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

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
6. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ 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:	Applicant A	Applicant B
7. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N
8. Did you turn age 65 in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N
9. Did you enroll in Medicare Part B in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N

If "YES," indicate your Medicare Part B effective date. ..... Applicant A ___/___/_____

Applicant B ___/___/_____

IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

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 10-21.

(If "YES" is answered to any of the following questions 10-20, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
12. Are you currently receiving any occupational, speech or physical therapy?	☐ Y ☐ N	☐ Y ☐ N
13. Within the past five 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?	☐ Y ☐ N	☐ Y ☐ N
14. Within the past five years have you been diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
15. Have you ever been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
B. Parkinson's Disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)?	☐ Y ☐ N	☐ Y ☐ N
C. Systemic lupus, sclerodrma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
D. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N	☐ Y ☐ N
E. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
G. Osteoporosis with fractures?	☐ Y ☐ N	☐ Y ☐ N
16. Have you ever been diagnosed with or treated for diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, any heart disorder (including hypertension/high blood pressure), stroke, transient ischemic attack (TIA) or kidney disease?	☐ Y ☐ N	☐ Y ☐ N
17. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N
18. 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?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	☐ Y ☐ N	☐ Y ☐ N
19. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐ Y ☐ N	☐ Y ☐ N
20. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
21. Have you taken any prescription drugs in the past 24 months? **(If YES, please complete the Medication Information sheet on the next page)**	☐ Y ☐ N	☐ Y ☐ N

H. Medication Information

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

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

I. Agreement and Authorization

IMPORTANT STATEMENTS

- **You do not need more than one Medicare supplement policy.**
- **If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.**
- **You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.**
- **If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the 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 state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).**

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO OMAHA INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Omaha 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, Omaha Insurance Company , 3300 Mutual of Omaha Plaza, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Omaha Insurance Company has taken action in reliance on the authorization or the law allows Omaha 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, 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 Omaha 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. Producer Comments (please attach a separate sheet if needed)

K. To be Completed by Producer

22. 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.

Applicant A
Applicant B

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

Applicant A
Applicant 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.

✍ _____ ✍ _____

Signature of Licensed Producer Date | Signature of Licensed Producer Date

_____ _____

Printed Name | Printed Name

Agent Writing Number | Agent Writing Number

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