

Agent Writing # 	DNIS _____ Auth # _____ Group # (if applicable) _____ Keyline _____
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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.

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Agent/Broker/Producer | <input type="checkbox"/> Family Member/Friend | <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Direct Mail | <input type="checkbox"/> Internet Search | <input type="checkbox"/> Radio | <input type="checkbox"/> TV |

A. Plan Information (to be completed by Producer)

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

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
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 _____	Current Age _____
Date of Birth / / mo day yr	Date of Birth / / mo day yr

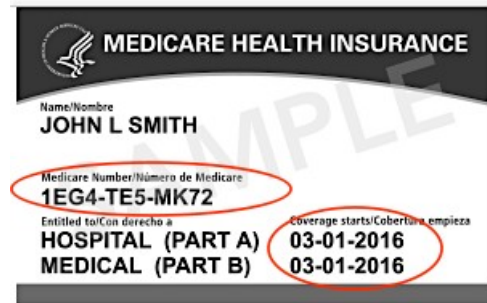
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B. Applicant Information (Continued)

Applicant A	Applicant B
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # <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"/>	Social Security # <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"/>
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 <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> If you are not covered under Medicare Part A, what is your eligibility 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"/>	Medicare Part A Effective 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"/> If you are not covered under Medicare Part A, what is your eligibility 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"/>
Medicare Part B Effective 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"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Medicare Part B Effective 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"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

D. Household Premium Discount Information

	Applicant A	Applicant B
You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.		
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		

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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

Applicant B

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement 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

Applicant B

Name of Company

Name of Company

Plan

Plan

Effective Date

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

☐ Y ☐ N

☐ Y ☐ N

(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.)
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

Applicant B

START

END

START

END

Applicant A

Applicant B

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

Applicant A

Applicant B

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

Applicant A

Applicant B

(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

Applicant B

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.)

Applicant A

Applicant B

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)

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**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
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
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)

Y

N

NS

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?

Y

N

NS

Y

N

NS

Y

N

NS

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
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	

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
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	
			<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	<div><div></div>Y<div><div></div></div>N<div><div></div></div>NS</div>	

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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 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).
- 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.

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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.

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.

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

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Agent Writing Number

Printed Name

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

Agent Writing Number

