

MUTUAL *of* OMAHA INSURANCE COMPANY

# APPLICATION for INDIVIDUAL DISABILITY INCOME

NEW YORK

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MUTUAL *of* OMAHA INSURANCE COMPANY  
Mutual of Omaha Plaza  
Omaha, NE 68175  
[mutualofomaha.com](http://mutualofomaha.com)

MAP426\_NY

# INDIVIDUAL DISABILITY INCOME

## Application Submission Checklist

**Application**

- 1 Must be taken during an in-person interview.
- 2 Answer all questions completely.
- 3 Be sure to leave all applicable forms with the proposed insured.
- 4 Sign and Date in all places indicated.
- 5 See reverse side of this page for detailed information.

**Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

**Collect Premium Amount**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

**Attach Copy of Quote (if available)**

**Schedule Paramed Exam as Applicable**

APPS 1-800-635-1677

PORTAMEDIC 1-800-765-1010

**Initiate the Client Profile process with the Proposed Insured  
Call 1-800-775-3000**

**Indicate Underwriting Requirements Initiated or Completed**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Client Profile Interview | <input type="checkbox"/> MD Exam    |
| <input type="checkbox"/> Blood Profile            | <input type="checkbox"/> EKG        |
| <input type="checkbox"/> Physical Data            | <input type="checkbox"/> Mammogram  |
| <input type="checkbox"/> Long Form                | <input type="checkbox"/> Urinalysis |

**Indicate Financial Requirements Completed**

- Financials are generally not required if applying for Short-Term Accident Only coverage up to \$3,000.
- Individuals who have been self-employed less than 12 months must provide a Profit and Loss/Expense Statement.

**Any Additional Information or Comments**

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**NOTE: BROKERAGE ONLY – Please list your “commission code” in the box on the first page of the application. This will help avoid delay in commission payment.**

**DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION**

**There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.**

#### **Part 1: APPLICATION**

- Notify the applicant that a telephone interview will be conducted to obtain additional information and/or to verify application information.

#### **Section A: General Questions/Other Coverage Information/Income Information**

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.
- All details of other coverages (in force or being applied for) must be listed.
- Complete all income information in full and provide details in the area provided.

#### **Section B: Accident Only Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section C: Short-Term, Long-Term or Business Operating Expense Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section D: Business Operating Expense Underwriting Information**

- Complete all information in full and provide details in the area provided.

#### **Section E: Plan Information**

- Complete all details of plan selected and rider information.

#### **Section F: Premium Information**

- The total premium amount must be listed. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual BSP), and amount of initial and renewal premium.
- If PRD mode, complete the PRD Authorization form.

#### **Section G: BSP Authorization**

- Specify date premiums will be withdrawn.
- Attach check for the account from which premiums will be withdrawn.

#### **Section H: Agreements**

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

#### **Part 2: ADMINISTRATIVE FORMS**

##### **Appendix 1: Authorization to Disclose Personal Information**

- The HIPAA authorization is to be signed and returned with the application.

##### **Appendix 2: Authorization to Receive Information From and Disclose Information to the MIB Group**

- The MIB authorization is to be signed and returned with the application.

##### **Appendix 3 : Agent/Producer Statement**

- This is necessary information for the underwriting process.

##### **Appendix 4, 5 & 6: Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice**

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

##### **Receipt and/or Temporary Health and Accident Insurance Agreement**

- Detach and leave with proposed insured.

##### **State-Specific Forms – complete if applicable**

- Be sure to include all state appropriate forms.

##### **Replacement Notice – complete if applicable**

- Complete and leave a copy with applicant (if applicable).

##### **HIV Consent Form – complete if applicable**

- Form must be signed and dated. Detach 1st copy and leave with Proposed Insured.

##### **Drug, Alcohol Usage, Avocation Questionnaires – complete if applicable**

- Complete all information in full, sign and date.

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By



Mutual of Omaha

# Application For:

Mutual of Omaha Insurance Company  
 Mutual of Omaha Plaza  
 Omaha, NE 68175

- ACCIDENT ONLY DISABILITY INSURANCE
- SHORT-TERM DISABILITY INSURANCE
- LONG-TERM DISABILITY INSURANCE
- BUSINESS OPERATING EXPENSE DISABILITY INSURANCE

**SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES**

**PROPOSED INSURED INFORMATION**

<p>1. Proposed Insured's Name (First, Middle, Last) _____</p> <p>2. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>3. Age _____ DOB ____/____/____</p> <p>4. Birth State _____</p> <p>5. Height (Ft &amp; In) _____ Weight (Lbs) _____</p> <p>6. Home Tel. Number ( _____ ) _____        Daytime Tel. Number ( _____ ) _____        Best Time to Call _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p> <p>7. Legal Residence Address (Number, Street, City, State, Zip) _____</p> <p>8. E-Mail Address (optional) _____</p> <p>9. Mailing Address for Premium Notices (Number, Street, City, State, Zip) _____</p> <p>10. Full name of beneficiary _____        Relationship to Proposed Insured _____</p> <p>11. Social Security Number _____ - _____ - _____</p> <p>12. Drivers License Number _____</p> <p>13. Are you a citizen of the United States?.....<input type="checkbox"/> Yes <input type="checkbox"/> No        If "No," please include your Permanent Resident Card form I-551 (also known as an "Alien registration Receipt Card" or "Green Card") number _____        and Visa Type _____</p>	<p>If not a citizen of the United States, have you resided in the United States at least 3 consecutive years?.....<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Employer _____        Address _____        Business Phone Number _____        Occupation _____        List exact duties _____</p> <p>15. How long have you been employed in your current position?        _____ Years _____ Months</p> <p>16. Proposed Insured's Employment Status:  <input type="checkbox"/> Employee (No Ownership)  <input type="checkbox"/> Sole Proprietor  <input type="checkbox"/> Partner in Partnership _____ % Ownership  <input type="checkbox"/> Shareholder in Sub "S" Corp. _____ % Ownership  <input type="checkbox"/> Owner of C - Corp. _____ % Ownership        Number of Full-time Employees _____        Do you have any part-time or off-season occupation?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," describe duties) _____</p> <p>17. Are you a member of an Association Group or Franchise?  <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," full name of organization _____        _____        Date joined (Mo./Yr.) _____ - _____</p>
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**OTHER COVERAGE AND REPLACEMENT INFORMATION**

1. Are you covered under or eligible for the Federal Employee's Compensation Act (FERS or CSRS) or the Railroad Retirement Act?..... Yes  No

2. Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance? .... Yes  No  
 If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.  
 I am requesting termination of my Policy No. \_\_\_\_\_ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

**INCOME INFORMATION**

<b>1. Income information</b> (Attach financial records if required. See underwriting guide for details)	Current Year	Prior Year
(a) Gross Annual Earned Income .....	\$ _____	\$ _____
(b) If self employed, net annual earned income from your occupation (after business expenses and before taxes).....	\$ _____	\$ _____
(c) Bonus, First Year Commissions and other incentive payments.....	\$ _____	\$ _____
(d) Other Earned Income (Part-time, off-season, etc.) .....	\$ _____	\$ _____
<b>Total</b> .....	\$ _____	\$ _____

**2.** During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed \$1,500 per month? .....  Yes  No

If "Yes," average over last 12 months..... \$ \_\_\_\_\_

**SECTION B Complete only if applying for Accident Only Disability Insurance**

<p><b>1.</b> During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? .....<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit a Drug or Alcohol Use Questionnaire)</p> <p><b>2.</b> During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? .....<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit an Avocation Questionnaire)</p>	<p><b>3.</b> During the last 3 years, have you had your drivers license suspended or revoked? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details _____</p> <p><b>4.</b> During the last 3 years, have you received or been advised by a healthcare provider (including chiropractor) to have treatment for any injury, impairment or disability? .....<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give details below. (Attach a separate signed sheet if necessary.)</p>
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Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION C Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.**

**1.** To the best of your knowledge and belief during the last 10 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 9.

<input type="checkbox"/> Kidney or Urinary Tract	<input type="checkbox"/> Anemia or Blood
<input type="checkbox"/> Cancer or Tumor	<input type="checkbox"/> Lung or Breathing Problem
<input type="checkbox"/> Heart or Coronary Arteries	<input type="checkbox"/> Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
<input type="checkbox"/> Alcohol or Drug Abuse	<input type="checkbox"/> Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)
<input type="checkbox"/> Liver or Hepatitis	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Stroke or Cerebral Vascular condition	<input type="checkbox"/> Skin or Connective Tissue
<input type="checkbox"/> Diabetes or Glandular condition	<input type="checkbox"/> Fibromyalgia or Myalgia
<input type="checkbox"/> Psychological, Emotional or Psychiatric condition	<input type="checkbox"/> Epstein-Barr Viral Infection
<input type="checkbox"/> Upper or Lower Digestive Tract	<input type="checkbox"/> <b>None of These</b>
<input type="checkbox"/> Spine, Neck or Back	
<input type="checkbox"/> High Blood Pressure, Arteries or Veins	
<input type="checkbox"/> Arthritis or Joints (including replacements)	

**SECTION C**

**Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance. - continued**

2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) .....  Yes  No
3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)?.....  Yes  No  
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name (copy from pharmacy label, if applicable)
Dosage/Frequency
Date
Reason
Prescribing Physician (if applicable)
Phone Number (if applicable)

4. To the best of your knowledge and belief during the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)?.....  Yes  No

5. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? .....  Yes  No  
(If "Yes," submit a Drug or Alcohol Use Questionnaire)

6. Have you:  
(a) ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company?.....  Yes  No  
If "Yes," provide details \_\_\_\_\_

- (b) ever applied for or received disability benefits of any kind?.....  Yes  No  
If "Yes," provide details \_\_\_\_\_

7. Are you pregnant?.....  Yes  No

8. To the best of your knowledge and belief other than previously answered, during the last 10 years have you (a) been advised to have any medical test or surgical operation that was not performed, or (b) had any medical test or surgical operation performed, or (c) gone to a hospital, doctors' office (including chiropractic), clinic, dispensary or sanatorium for observation, examination or treatment? .....  Yes  No

9. Complete this section to expand on questions 1 and 8 in Section C. (Attach a separate signed sheet if necessary.)

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

**SECTION D**

**Complete only if applying for BUSINESS OPERATING EXPENSE Insurance**

1. Is your business conducted at your place of residence? .....  Yes  No  
If "Yes," what percent of your duties are performed outside of your place of residence? ..... \_\_\_\_\_ %
2. Date business established?..... \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

**Average Monthly Expenses:**

No. of employees	_____	Water	\$ _____
Employees' salaries	\$ _____	Telephone	\$ _____
Interest on loans	\$ _____	Postage and stationery	\$ _____
Mortgage interest payments	\$ _____	Equipment rental	\$ _____
Insurance (casualty/liability)	\$ _____	Laundry	\$ _____
Property taxes (real and personal)	\$ _____	Other fixed operating expenses (please itemize)	_____
Depreciation (office equipment only)	\$ _____	_____	\$ _____
Rent (including land rental)	\$ _____	_____	\$ _____
Electricity	\$ _____		
Heat	\$ _____	<b>Total Monthly Expenses</b>	<b>\$ _____</b>

**SECTION E PLAN INFORMATION**

**ACCIDENT ONLY DISABILITY INSURANCE**

**Monthly Benefit Amount \$** \_\_\_\_\_

**Elimination Period:**  14 Days  30 Days  60 Days  90 Days

**Benefit Period:**  3 Months  6 Months  12 Months  24 Months

**Optional Riders:**  
 Hospital Confinement Accident Indemnity Benefits Rider  \$125  \$250  \$350  \$500

**SHORT-TERM DISABILITY INSURANCE**

**Monthly Benefit Amount \$** \_\_\_\_\_

**Elimination Period Accident/Sickness:**  14 Days  30 Days  60 Days  90 Days

**Benefit Period:**  3 Months  6 Months  12 Months  24 Months

**Optional Riders:**  
 Hospital Confinement Indemnity Benefits Rider  \$125  \$250  \$350  \$500  
 Specified Disease Benefits Rider (check one option)  \$5,000  \$10,000  \$15,000  \$25,000

If applying for Specified Disease Benefits Rider, complete additional health question below:  
 Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. ....  Yes  No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

**LONG-TERM DISABILITY INSURANCE**

**Base Monthly Benefit Amount \$** \_\_\_\_\_ **SIS Monthly Benefit Amount \$** \_\_\_\_\_

**Elimination Period:**  60 Days  90 Days  180 Days  365 Days

**Benefit Period:**  2 Years  5 Years  10 Years  To Age 67

**Optional Riders:**

<input type="checkbox"/> SIS (Social Insurance Substitute) Benefits Rider Do you have any dependent children age 17 or under? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you covered under the Social Security Act? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Hospital Confinement Indemnity Benefits Rider (check one option) <input type="checkbox"/> \$125 <input type="checkbox"/> \$250 <input type="checkbox"/> \$350 <input type="checkbox"/> \$500  <input type="checkbox"/> Specified Disease Benefits Rider (check one option) <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000	<input type="checkbox"/> Extended Proportionate Disability Benefits Rider <input type="checkbox"/> Future Insurability Option (FIO) Rider <input type="checkbox"/> Extended Own-Occ. Disability Defin. Amend. Rider <input type="checkbox"/> Cost-of-Living Adjustment (COLA) Rider
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If applying for Specified Disease Benefits Rider, complete additional health question below:  
 Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. ....  Yes  No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

**BUSINESS OPERATING EXPENSE DISABILITY INSURANCE**

Monthly Benefit Amount \$ \_\_\_\_\_

Elimination Period:  30 Days  60 Days  90 Days  180 Days  365 Days

Benefit Period:  12 Months  18 Months

**SECTION F PREMIUM COLLECTION**

Amount Collected \$ \_\_\_\_\_ Initial Premium \$ \_\_\_\_\_ Renewal Premium \$ \_\_\_\_\_

Billing Mode:  Monthly  Quarterly  Semiannual  Annual

Bank Service Plan (BSP) - Complete 'Authorization to Withdraw Funds' (If BSP is selected, collect 2 months of premium.)

Payroll Deduction

Add to Existing PRD – Group Number..... \_\_\_\_\_

First Deduction Date ..... \_\_\_\_\_

Number of Deductions..... \_\_\_\_\_

Effective Date of Payroll Deduction ..... \_\_\_\_\_

**SECTION G Complete only if Billing Mode is BSP**

**AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")**

As a convenience to me, I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn:  1st of the Month or  15th of the Month
2. Attach your check from the account from which premiums will be withdrawn.

**SECTION H PLEASE READ AND SIGN**

**AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. ("MIB")**

– The MIB Group, Inc. ("MIB") is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to Mutual of Omaha Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize Mutual of Omaha Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

**AGREEMENT** – I, the undersigned, agree that (a) all answers in this application are true and complete to the best of my knowledge and belief (b) Mutual of Omaha Insurance Company will rely upon these answers to determine insurability and the application and any supplements shall become part of the applied for policy.

If the full initial premium is paid on the date of the completed application (or on the first premium deduction date), and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the date of the policy will be the date of the application or the expiration of any replaced coverage, if later. I agree no temporary or interim insurance of any kind will be in effect, except as may be provided in any Conditional Receipt.

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, I must complete all required examinations and tests (medical, paramedical, laboratory), and Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests and any other information (such as an Attending Physician's Statement) that is requested by Mutual of Omaha Insurance Company to underwrite the application. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date.

No Agent/Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

**SECTION H****PLEASE READ AND SIGN - continued**

**FRAUD WARNING** – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**I have (a) read and understand the Agreement and Fraud Warning Section and any Receipt provided; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.**

\_\_\_\_\_  
Signature of Proposed Insured                      Printed Name of Proposed Insured                      Date

\_\_\_\_\_  
Signature of Payor as shown on bank account                      Printed Name of Payor                      Date  
(if Billing Mode is BSP and Payor is other than Proposed Insured)

**I/We certify that during an in-person interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ....**  Yes  No

(If "No," please explain.) \_\_\_\_\_

\_\_\_\_\_  
Signature of Producer                      Producer's Printed Name                      Date

\_\_\_\_\_  
Office Name                      Office Address

\_\_\_\_\_  
Signature of Producer                      Producer's Printed Name                      Date

\_\_\_\_\_  
Office Name                      Office Address

# Conditional Receipt

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

**Initial Premium paid by check**  
Money was collected - Received \$ \_\_\_\_\_ from \_\_\_\_\_ paid with an insurance application on \_\_\_\_\_, dated \_\_\_\_\_.  
(person(s) proposed for insurance)

**(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)**

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of the first medical examination and all tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Completion by the Proposed insured of a second medical examination if required by Mutual of Omaha Insurance Company's underwriting rules because of the amount of insurance applied for or the applicants age.
5. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
6. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) \$50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: \_\_\_\_\_ Signed at: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Signature of Producer

# Conditional Receipt

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

**Initial Premium paid by check**  
Money was collected - Received \$ \_\_\_\_\_ from \_\_\_\_\_ paid with an insurance application on \_\_\_\_\_, dated \_\_\_\_\_.  
(person(s) proposed for insurance)

**(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)**

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of the first medical examination and all tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Completion by the Proposed insured of a second medical examination if required by Mutual of Omaha Insurance Company's underwriting rules because of the amount of insurance applied for or the applicants age.
5. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
6. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) \$50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: \_\_\_\_\_ Signed at: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Signature of Producer

**Meanings of Terms**

**“Medical Persons and Entities” means:** all physicians, 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.

**“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 and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** 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.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Disclose**

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

**Purposes**

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

**Potential for Rediscovery**

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.

**Failure to Sign**

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

**Expiration and Revocation**

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting  
Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

**Copy**

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Spouse’s Printed Name  
(If Proposed Insured)

\_\_\_\_\_  
If children are to be insured, their printed names

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Spouse  
(If Proposed Insured)

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

**Meanings of Terms**

**"MIB Group, Inc. (MIB)" means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**"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 and, if my children are proposed insureds, my children also.

**"Specified Companies" means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

- 1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.)..... Yes  No
- 2 Has a medical examination of the Proposed Insured been scheduled?..... Yes  No  
If "Yes," when? \_\_\_\_\_ By \_\_\_\_\_
- 3 Has the client profile interview been completed? ..... Yes  No  
If "No," the client profile interview has been scheduled for \_\_\_\_\_ and \_\_\_\_\_  
Date Time (Please circle -Eastern, Central, Mountain or Pacific)
- 4 Did you give the Notice of Information Practices to the Proposed Insured?..... Yes  No  
Date \_\_\_\_\_  
Mo. Day Yr. \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_

**Agent/Producer Information:**

Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____
Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____

**Appendix 4****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. 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.**

**Appendix 5****Mutual of Omaha Insurance Company  
MIB Group, Inc. Pre-Notice**

The information regarding your insurability will be treated as confidential.

However, the Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply for life and health insurance to another company which is also a member of MIB or if a claim for benefits is submitted to such a company, MIB will, upon request, supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is P.O. Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.

In compliance with applicable law, the Company or its reinsurers may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

**Appendix 6****Mutual of Omaha Insurance Company  
Investigative Consumer Reports Notice**

Mutual of Omaha Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

# Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:  
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:  
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

## Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result \_\_\_\_\_

Address \_\_\_\_\_

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

## Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

# Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Mutual of Omaha Insurance Company

- ATTN: Health:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: True Group:  
Mutual of Omaha Plaza, Omaha, NE 68175

Companion Life Insurance Company

- ATTN: Life Agency:  
Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage:  
P.O. Box 2476, Omaha, NE 68103-2476

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

## Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result \_\_\_\_\_

Address \_\_\_\_\_

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

## Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

# Drug Usage Questionnaire

Mutual of Omaha Insurance Company  
 Mutual of Omaha Plaza  
 Omaha, NE 68175  
 Attn: Individual Health Underwriting

1. Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

2A. To the best of your knowledge and belief are you now using or during the last 10 years have you ever used any of the following drugs:

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| (a) Opium derivatives: Heroin, Morphine, Demerol, Methadone, Codeine, Percodan, Dilaudid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Marijuana: Hashish, Cannabis.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Amphetamines: Benzedrine, Dexedrine, Methedrine, Preludin .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Cocaine, Crack.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Hallucinogens: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Sedatives and Tranquilizers: Librium, Valium, Quaalude, Dalmane, Placidyl.....            | <input type="checkbox"/> | <input type="checkbox"/> |

2B. Were any of the above prescribed by a physician?  Yes  No If "Yes," which? \_\_\_\_\_

3. If "Yes" answers in 2A or 2B, please give details.

Type	Usual Quantity	Frequency of Use	How Taken (Oral, Injection, Inhaled, Smoked, Etc.)	Date: From — To

4. Except those prescribed by a physician, are you now using or have you used during the last 10 years any other drugs not listed in number 2 or 3 above?  Yes  No If "Yes," explain. \_\_\_\_\_

5. To the best of your knowledge and belief have you ever sought medical treatment because of drug usage?  Yes  No  
 If "Yes," state dates and names of doctors and institutions consulted. \_\_\_\_\_

6. Please indicate any additional relevant information. \_\_\_\_\_

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 Signature of Proposed Insured

# Alcohol Use Questionnaire

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
Attn: Individual Health Underwriting

---

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

1. Do you presently use alcoholic beverages?  Yes  No If "No," date of last drink. \_\_\_\_\_  
If "Yes," please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. To the best of your knowledge and belief did you ever drink substantially more than at present?  Yes  No If "Yes," during what time period?

Dates: From \_\_\_\_\_ To \_\_\_\_\_  
Please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Why did you change your drinking habits? \_\_\_\_\_  
\_\_\_\_\_

3. Are you active in Alcoholics Anonymous or other recovery groups?  Yes  No How long? \_\_\_\_\_

4. To the best of your knowledge and belief have you ever consulted a doctor or received treatment because of your alcohol use?  Yes  No

If "Yes," indicate name and address of any doctor, hospital or treatment center and dates of treatment. \_\_\_\_\_  
\_\_\_\_\_

5. To the best of your knowledge and belief are you presently taking, or have you ever taken, Antabuse or any other medication to control your drinking?  
 Yes  No If "Yes," please indicate date last used and name of doctor who prescribed it. \_\_\_\_\_  
\_\_\_\_\_

6. To the best of your knowledge have you ever been arrested for driving under the influence of alcohol?  Yes  No  
If "Yes," give dates and driver's license number. \_\_\_\_\_  
\_\_\_\_\_

7. To the best of your knowledge and belief have you ever used any other drugs, except over-the-counter drugs or those prescribed by a physician?  
 Yes  No (If answered "Yes," please complete Drug Usage Questionnaire.)

8 Remarks \_\_\_\_\_

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Witness \_\_\_\_\_ Signature of Proposed Insured \_\_\_\_\_

# Avocation Questionnaire

Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
Attn: Individual Health Underwriting

---

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

## 1. Type of Avocation:

- Motorcycle Racing
- Auto Racing
- Boat Racing
- Stunt Driving
- Aircraft Piloting
- Rodeo Activities
- Rock/Mountain Climbing
- Sky Diving
- Scuba Diving
- Other \_\_\_\_\_

2. How many times per year do you participate in this activity? \_\_\_\_\_

3. Do you plan to continue participating in this activity in the future?  Yes  No

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Proposed Insured

# Foreign National and Foreign Travel Questionnaire



## To be completed by Proposed Insured(s) or Policyowner(s)

- 1** Are you a U.S. citizen?.....  Yes  No  
**(If "Yes," proceed to Question 2.)**
- (a) Are you a Permanent Resident (holder of a Permanent Resident Card)?.....  Yes  No  
(1) If "Yes," please list your Permanent Resident Card Number: \_\_\_\_\_  
(2) If "No," please list the type of visa you hold: \_\_\_\_\_ How long have you lived in the United States? \_\_\_\_\_
- (b) Please provide your full name as stated on the Permanent Resident Card or Visa: \_\_\_\_\_  
\_\_\_\_\_
- (c) Date of issue on your Permanent Resident Card or Visa: \_\_\_\_\_
- (d) Date of expiration on your Permanent Resident Card: \_\_\_\_\_
- (e) Country of Birth: \_\_\_\_\_
- (f) Do you own a home in the United States.?.....  Yes  No  
If "Yes," please provide the address: \_\_\_\_\_
- (g) Do you own a home in a foreign country? .....  Yes  No  
If "Yes," please provide the address: \_\_\_\_\_
- (h) If married, does your family live with you in the United States?.....  Yes  No
- 2** Are you employed in the United States? .....  Yes  No
- (a) If "Yes," please provide the name and address of your employer and describe the duties you perform. \_\_\_\_\_  
\_\_\_\_\_
- (b) If "No," please provide source(s) of income while living in the United States. \_\_\_\_\_  
\_\_\_\_\_
- 3** Do you plan to travel outside of the United States in the next two years? .....  Yes  No  
**(If "Yes," please answer the following questions below:)**
- (a) Where do you plan to travel? \_\_\_\_\_
- (b) What is the purpose of travel?  Business  Pleasure
- (c) How often? \_\_\_\_\_
- (d) Average period of time for each trip: \_\_\_\_\_
- (e) What was the date of your last trip? \_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Signature(s) of Proposed Insured(s) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature(s) of Policyowner(s) \_\_\_\_\_  
Date

**Producer Statement:** In the presence of the insured(s) I have asked each question as written and have recorded the answers completely and accurately. If question 1 was answered "No," I have seen the proposed insured(s) or policyowner(s) Permanent Resident Card.....  Yes  No

If "No," please provide explanation. \_\_\_\_\_

\_\_\_\_\_  
Signature(s) of Producer(s) \_\_\_\_\_  
Date

**Meanings of Terms**

**“Medical Persons and Entities” means:** all physicians, 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.

**“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 and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** 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.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Disclose**

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

**Purposes**

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

**Potential for Rediscovery**

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.

**Failure to Sign**

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

**Expiration and Revocation**

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting  
Mutual of Omaha Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

**Copy**

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

_____ Printed Name of Proposed Insured	_____ Spouse’s Printed Name (If Proposed Insured)	_____ If children are to be insured, their printed names
_____ Signature of Proposed Insured	_____ Signature of Spouse (If Proposed Insured)	_____ Signature of Parent or Guardian (If Proposed Insured is a Minor)
_____ Date	_____ Date	_____ Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**