Mutual *of* Omaha Insurance Company

APPLICATION *f*or - LONG-TERM CARE

INDIANA

Mutual *of* Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

Mutual *of* Omaha Insurance Company

LONG-TERM CARE Application Submission Checklist

This application packet includes the application and state required forms.

Tear out and leave with the applicant the indicated forms

Submit the remainder of the packet intact with every question on the application and applicable forms completed. Unanswered questions or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If the question does not apply to your client answer it as "No" or "None" rather than "N/A"

If the applicant answers "yes" to any question in Section C they are ineligible for coverage. Do not submit the application.

Include a copy of your quote with the packet

Indicate on the application the best time to contact the applicant to schedule the interview and inform them of the telephone interview or face to face interview process. Provide them with a copy of "The Importance of an Accurate Health History".

ADMINISTRATIVE APPENDIX FORMS

Privacy Authorization

Sign and date the form and leave it attached to the application

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company (Monthly Bank Draft)

Complete, sign and date if applicable

Payments will be deducted monthly on the date specified. Account information will be taken from the accompanying premium check. If no premium is submitted, attach a voided check.

Association/Employer Sales

Complete only for Association or Franchise Coverage

Producer Statement

Include your telephone number and email address

If someone other than you should be contacted for questions regarding the pending application, provide their name, phone number, and email address

Receipt and/or Temporary Health and Accident Insurance Agreement

Detach and leave with the applicant

Notice of Information Practices

Detach and leave with the applicant

Financial Institution Consumer Disclosure

If this insurance product or annuity is sold, solicited, advertised or offered to a customer at an office of the financial institution, or on behalf of the financial institution, the "Financial Institution Consumer Disclosure" form must be presented and signed at the time of application, and a copy provided with the submitted application.

Activities on behalf of a financial institution include activities where a person, whether at the office of the financial institution or at another location, sells, solicits, advertises, or offers an insurance product or annuity and at least one of the following applies:

- The person represents to a consumer that the sale, solicitation, advertisement or offer of any insurance product or annuity is by or on behalf of the financial institution,
- The financial institution refers a consumer to a seller of insurance products and annuities and the financial institution has a contractual arrangement to receive commissions or fees derived from a sale of an insurance product or annuity resulting from that referral, or
- Documents evidencing the sale, solicitation, advertising, or offer of an insurance product or annuity identify or refer to the financial institution.

For Brokerage	Commission Code	951300	Application Reviewed By

For Mutual of Omaha Career Agents	Manager Stamp 01	District Sales Manager Stamp	Application Reviewed By

Long-Term Care Insurance Application - Individual

Insurance Underwritten By:
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Submit Application To:
Long-Term Care Service Office:
P.O. Box 64901
St. Paul, MN 55164-0901

☐ **New Business**
☐ **Reinstatement**
☐ **Replacement**
If Group or Association, List Name _____

A General Questions

Proposed

1 Insured ("You") _____ (First Name) _____ (MI) _____ (Last Name)

☐ Male ☐ Female Date of Birth ___ (Mo.) – ___ (Day) – ____ (Yr.) Age ___

Social Security Number ___ – ___ – ____

2 Legal residence address _____ (Number, Street, Apartment Number)

_____ (City and State) (ZIP Code)

Type of Residence ☐ Home ☐ Apartment ☐ Retirement Community ☐ Other _____

3 Phone Number Home ___ – ___ – ____ Work ___ – ___ – ____

Best time to call ___ a.m. ___ p.m. ☐ Home ☐ Work

4 E-mail address _____

5 Are You a U. S. citizen? ☐ Yes ☐ No If "No," date of arrival in U. S. ___ (Mo.) – ___ (Yr.)

Do You have a Permanent Resident Card - Form I-551 (also known as a "Green Card")?
☐ Yes If "Yes," Card Number _____ ☐ No If "No," You are not eligible for this coverage.

		Yes	No
6	During the last 6 months, have You been continuously and actively at work for a minimum of 32 hours per week?	☐	☐
7	Are You married? ☐ Yes ☐ No (If "Yes," is Spouse applying for this coverage?)	☐	☐
	Are You single, continuously residing in a Two-Person Household for the last 12 months?	☐	☐
	(If "Yes," is the other person residing with You applying for this coverage?)	☐	☐

Full Name of other Applicant _____ (First Name) _____ (MI) _____ (Last Name)

Social Security Number ___ – ___ – ____

8 Full Name of Beneficiary _____ (First Name) _____ (MI) _____ (Last Name)

Relationship to You _____

9 Beneficiary's Address _____ (Number, Street, Apartment Number)

_____ (City and State) (ZIP Code)

THE POLICY DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG-TERM CARE PROGRAM. HOWEVER, THE POLICY IS AN APPROVED LONG-TERM CARE INSURANCE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG-TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DEPARTMENT OF INSURANCE AT 1-800-452-4800.

B Other Coverage

			Yes	No
1	**a**	Do You currently have another long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)?	☐	☐
	b	Did You have another long-term care policy or certificate in force during the last 12 months?	☐	☐
	c	Do You intend to replace other long-term care coverage or any of Your medical or health insurance coverage with this policy/certificate?..... **If "Yes," please read and sign the replacement notice provided by the producer.**	☐	☐

For Replacements only, Requested Effective Date of Coverage _____
(Up to 60 days beyond application date.) Mo. Day Yr.
(If issued, coverage will be effective on the date indicated here.)

If "Yes," is answered to any question in Section B1 above, provide details below:

Company Name/Address	Policy #	Type of Plan	Daily Benefit	Lapse Date	Annual Premium

2 Producers shall list all health insurance policies You have which are still in force _____

_____ or ☐ None

Producers shall list all health insurance policies they sold to You in the past five years, which are no longer in force

_____ or ☐ None

Producers shall list all health policies they sold to You which are still in force _____

_____ or ☐ None

		Yes	No
3	Have You ever been declined, rated, or denied reinstatement for long-term care insurance?	☐	☐

If "Yes," Name of Company _____

When _____

Why (if known) _____

C Health Insurability Questions

		Yes	No
1	Do You currently use any of the following: • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐
2	Within the past 6 months have You been confined to a/an, or been advised to have... • residential care facility • assisted living facility • physical therapy • adult day care facility • home health care services • occupational therapy • nursing home • speech therapy	☐	☐
3	Do You require the assistance or supervision of another person or a device of any kind for any of the following: • bathing • toileting • dressing • getting in and out of a chair or bed • eating • Your inability to control Your bowel or bladder • medication management	☐	☐
4	Have you been diagnosed or treated by a member of the medical profession as having Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic)?	☐	☐
5	Are You scheduled for an upcoming surgery requiring general anesthesia, or have You been advised to have surgery requiring general anesthesia and not done so?	☐	☐
6	Do You have Diabetes and have numbness or tingling in Your feet, foot ulcers, an amputation, diabetic eye disease, kidney disease, or take more than 50 units of insulin per day?	☐	☐
7	Do You have Diabetes and have You ever had a Stroke/Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA)?	☐	☐
8	Within the last 10 years have You been diagnosed as having, or received medical care for, any of the following: • Alzheimer's Disease • Chronic Hepatitis • Amyotrophic Lateral Sclerosis (ALS) • Dementia • Cirrhosis • Huntington's Chorea • Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis • Mental Retardation • Parkinson's Disease • Paralysis • Schizophrenia • Multiple Sclerosis • Scleroderma • Psychosis • Muscular Dystrophy • Systemic Lupus • Alcohol or Drug Use • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or • Amputation due to disease Chronic Bronchitis and have used tobacco in the past 12 months	☐	☐
9	Have You ever had two or more Strokes/CVA's or TIA's, have weakness or loss of function from a previous Stroke/CVA or TIA, or have had a single Stroke/CVA in the past 2 years?	☐	☐
10	In the past 2 years have You been diagnosed with Cancer or received treatment for Cancer? (Except basal and squamous cell skin cancers; stage I/A breast, bladder, prostate or thyroid cancers.)	☐	☐
11	Have You ever had an Organ Transplant?	☐	☐
12	Are You currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers' compensation, social security disability, or any federal or state disability plan?	☐	☐

STOP – If You answered "Yes" to any of the questions 1 through 12 of Section C above do not continue further. We will be unable to accept this application or offer You Long-Term Care insurance.

If You answered "No" to every question, please continue.

NOTE: Even though we cannot accept Your application if You answered "Yes" to any of questions 1 through 12 of Section C above, Your spouse may qualify to add the "Spouse Benefit" to his/her application.

D Medication and Physician Information

		Yes	No
1	Are You taking or have You taken any prescription medications within the past 12 months?	☐	☐
2	Are You taking or have You taken any over-the-counter medication(s) on a daily or weekly basis?.....	☐	☐

If "Yes," is answered to either question 1 or 2, please list the medication and the following information.

Medication Name (copy from pharmacy label)	Dosage	Frequency	Disease/Disorder/Condition

3 Height _____ (Feet and Inches) Weight _____ (Pounds)

4 Name of Primary Physician _____

Address of Primary Physician _____

_____

Date of Last Visit _____ Reason for Last Visit _____

Have You seen this or any other physician in the last 2 years? ☐ Yes ☐ No

E Health Questions

		Yes	No
1	Within the last 5 years, have You received any advice, treatment or consultation from a physician or health care provider for:	☐	☐

Check all that You are answering as Yes –

☐ Stroke or Transient Ischemic Attack	☐ Cancer	☐ Fibromyalgia
☐ High Blood Pressure	☐ Vision Disorder	☐ Osteoporosis
☐ Circulatory Disease/Disorder	☐ Diabetes	☐ Broken Bones
☐ Heart Disease/Disorder	☐ Depression/Other Mental Disorder	☐ Falls
☐ Respiratory Disease/Disorder	☐ Seizures, Epilepsy, Tremors	☐ Dizziness or Fainting
☐ Kidney or Liver Disease/Disorder	☐ Neurological Disease/Disorder	☐ Balance Disorder or
☐ Immune System Disease/Disorder	☐ Bowel or Bladder Disease/Disorder	Difficulty Walking
☐ Anemia or Blood Disease/Disorder	☐ Arthritis, Bone or Joint Disorder	☐ Weakness or Fatigue

2	Have You received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?	☐	☐
3	Are You scheduled for, or have You been advised by a physician or health care provider to have additional testing or consultation(s) to evaluate Your health?	☐	☐
4	Are there any pending test results which You have not yet received?	☐	☐
5	Have You been seen by Your physician, health care provider or any specialists more than three times in the past 12 months?	☐	☐
6	Have You obtained a handicap sticker or handicap license plate?	☐	☐

Provide details below for all questions answered "Yes" in this Section E:

Disease/Disorder/Condition	Date of Occurrence/ Date of Last Visit	Physician/Facility Information
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #

F Plan Information **(Availability of all plans and coverages are subject to change.)**

Long-Term Care I

One Maximum Lifetime Benefit
Tax Qualified Only

Maximum Lifetime Benefit Multiplier	Elimination Period
☐ 1095 (3 Yrs)	☐ 30 days
☐ 1825 (5 Yrs)	☐ 90 days
☐ Unlimited	

$ _____
Maximum Daily Benefit

Optional Benefits for Long-Term Care I
☐ Spouse Waiver of Premium and Survivorship Benefit
☐ Shortened Benefit Period Nonforfeiture

Choose one Payment Period Option and Inflation Protection Option:

Payment Period Options	Inflation Protection Options
☐ **Lifetime Premium Payment;** or	☐ Compound (Lifetime) 5% ☐ No Inflation Protection
☐ **10 Years Premium Payment *** ☐ **Premium Payments To Age 65***	☐ Compound (Lifetime) 5% ☐ No Inflation Protection

(*Not available with Spouse Waiver of Premium and Survivorship Benefit Option.)

Mode Selected:
☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft ☐ Payroll Deduction ☐ List Bill – Employer Paid

Payroll Location _____

Premium Collected $ _____ Mode Premium $ _____

Mailing address for premium notices _____
Number, Street, Apartment Number

_____
City and State ZIP Code

F Plan Information (Continued) **(Availability of all plans and coverages are subject to change.)**

Long-Term Care II

One Maximum Lifetime Benefit
Tax Qualified

Nursing Home/Assisted Living

Maximum Lifetime Benefit Multiplier

- ☐ 730 (2 Yrs)
- ☐ 1095 (3 Yrs)
- ☐ 1460 (4 Yrs)
- ☐ 1825 (5 Yrs)
- ☐ Unlimited

Elimination Period

- ☐ 0 days ☐ 90 days
- ☐ 30 days ☐ 180 days
- ☐ 60 days ☐ 365 days

$ _____
Maximum Daily Benefit

Home Health Care

- ☐ up to 50% of Maximum Daily Benefit
- ☐ up to 100% of Maximum Daily Benefit

☐ Waiver of Elimination Period - Home Health Care

Long-Term Care II

Two Maximum Lifetime Benefits
Tax Qualified

Nursing Home/Assisted Living

Maximum Lifetime Benefit Multiplier

- ☐ 730 (2 Yrs)
- ☐ 1095 (3 Yrs)
- ☐ 1460 (4 Yrs)
- ☐ 1825 (5 Yrs)
- ☐ Unlimited

Elimination Period

- ☐ 0 days ☐ 90 days
- ☐ 30 days ☐ 180 days
- ☐ 60 days ☐ 365 days

$ _____
Maximum Daily Benefit

Home Health Care

Maximum Lifetime Benefit Multiplier

- ☐ 730 (2 Yrs)
- ☐ 1095 (3 Yrs)
- ☐ 1460 (4 Yrs)
- ☐ 1825 (5 Yrs)
- ☐ Unlimited

Elimination Period

- ☐ 0 days ☐ 90 days
- ☐ 30 days ☐ 180 days
- ☐ 60 days ☐ 365 days

$ _____
Maximum Daily Benefit
Round up $10 increments
50% minimum required

Coverage Options for Long-Term Care II

- ☐ Non-Tax Qualified Plan
- ☐ Shortened Benefit Period Nonforfeiture
- ☐ Return of Premium at Death Less Claims
- ☐ Spouse Waiver of Premium and Survivorship Benefit
- ☐ Spouse Benefit
  (Available for applicants ages 69 or younger)
- ☐ Nursing Home/Assisted Living Indemnity Coverage
- ☐ Monthly Payment of Home Health Care

Spouse's Name _____ – __ – _____
First Name MI Last Name

Spouse's Social Security Number ___ – __ – ____

Choose one Payment Period Option and Inflation Protection Option:

Payment Period Options

- ☐ **Lifetime Premium Payments;** or
- ☐ **10 Year Premium Payment***
- ☐ **Premium Payments To Age 65***

Inflation Protection Options

- ☐ No Inflation Protection
- ☐ Compound (Lifetime) 5%

- ☐ No Inflation Protection
- ☐ Compound (Lifetime) 5%

(*Not available with Spouse Waiver of Premium and Survivorship Benefit Option.)

Mode Selected:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft ☐ Payroll Deduction ☐ List Bill – Employer Paid

Payroll Location _____

Premium Collected $ _____ Mode Premium $ _____

Mailing address for premium notices _____
Number, Street, Apartment Number

_____
City and State ZIP Code

G Notice Before Lapse or Termination

Please complete the following applicable box, sign and date.

☐ I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

Third Party _____
Please print the full name of other person to receive notice of lapse or termination

Third Party's Home Address _____
Street No. City State ZIP Code

Waiver: Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium.

I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

☐ I elect NOT to designate any person to receive such notice.

X _____ Date _____
Signature of Proposed Insured Mo. Day Yr.

H Agreements

Agreement – I, the undersigned, and the undersigned Producer(s), agree that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely upon these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application 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 effective date of the policy will be the date of the application, or, if later, the expiration of any replaced coverage.

The underwriting standards of Mutual of Omaha Insurance Company will not be applied to changes in health after the application date unless a medical examination (including a personal health interview) or medical test is required. In order for the policy applied for to be issued, all required medical examinations and tests must be completed, and Mutual must receive the reports from all required medical examinations and tests, and any other information (such as an Attending Physician's Statement) that is requested. 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. **If I am not eligible for the insurance applied for or any substitute policy, I agree that no policy of any kind will be in effect, except for coverage provided by any Temporary Insurance Agreement.**

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

I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy/certificate with and without inflation protection option. Specifically, I have reviewed options for Compound Inflation increases, and I reject the 5% Compound Inflation Protection option.

_____**Initials of Proposed Insured**

I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that has been made available and I reject the "Nonforfeiture Benefit **-** Shortened Benefit" Option that is available.

_____**Initials of Proposed Insured**

I acknowledge receipt of, if applicable:

- ☐ **Outline of Coverage**
- ☐ **Long-Term Care Insurance Personal Worksheet**
- ☐ **Privacy Notice**
- ☐ **Shopper's Guide to Long-Term Care Insurance**
- ☐ **Guide to Health Insurance for People with Medicare**
- ☐ **Potential Rate Increase Disclosure Form**

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 subjects such person to criminal and civil penalties.

Caution: If Your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company has the right to deny benefits or rescind Your policy.

I have read and understand the Agreement and Fraud Warning Sections and the Receipt provided, and I have read and approve all my answers as recorded in this application.

Signed at _____ (City) _____ (State) Date _____ (Mo.) _____ (Day) _____ (Yr.)

X _____
Signature of Proposed Insured

I/We, the Producer(s) certify that each question was asked exactly as written and I/We have recorded the answers provided by the Proposed Insured completely and accurately. ☐ Yes ☐ No (If "No," please explain) _____

_____

X _____
Signature of Licensed Producer

_____
Office Name

_____
Office Address

X _____
Signature of Licensed Producer

_____
Office Name

_____
Office Address

Appendix 1 Indiana – Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

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, 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 of Omaha Life 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 Redisclosure

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

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

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

Appendix 2 Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

1 List the policies to be paid by your checking account:

(a) _____ _____ (b) _____ _____
Form Proposed Insured Form Proposed Insured

(c) |_|_|_|_|_|_|_|_|_| |_|_|_|_|_|_|_|_|_|_|
Bank Routing Number Checking Account number

2 Complete the following only if You are adding the above coverages to an existing Bank Service Plan (BSP) account.

_____ _____
Insured Under Existing BSP Existing BSP Policy/Certificate Number

3 Specify the date premiums will be withdrawn from your checking account |__|__|
Choose a day between 1-28 of the Month

4 Attach your check from the account from which premiums will be withdrawn.

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 Insurance Company listed above. 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.

Date_____ X_____ X_____
Mo./Day/Yr. Authorized Signature as Shown on Account Joint Account or Other Authorized Signature

Appendix 3 Association/Employer Sales

Association Information:

Full Name of Organization _____

Relationship to above:
☐ Member ☐ Spouse of Member ☐ Other Qualifying Family Member(s)
(Adult children age 18 and older, Parents and/or Parents-in-Law, Other _____)

Name of Association Member _____

Employer Information (if employer sponsored):

Company Name _____

Name of Owner/President _____

Company Address _____

City _____ State _____ ZIP Code _____

Service Group Number _____

☐ Full Time Employee ☐ Part Time Employee ☐ Spouse of Employee ☐ Retired

Appendix 4 Producer Statement

		Yes	No
1	I/We certify that the Notice of Information Practices was given to the Proposed Insured.	☐	☐
2	I/We certify that each question was asked exactly as written and recorded the answers completely and accurately in the presence of the Proposed Insured.	☐	☐

(If "No," explain) _____

Date _____ Signature of Producer _____

Date _____ Signature of Producer _____

Producer Information

Producer's Name _____ Social Security No. _____

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____

Mgr./Marketer Phone Number (_____)_____

Producer's Stamp _____ Producer's License/Identification # _____

Producer's Name _____ Social Security No. _____

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____

Mgr./Marketer Phone Number (_____)_____

Producer's Stamp _____ Producer's License/Identification # _____

Who should we contact with questions regarding this pending application:

Name _____

Phone Number (_____)_____

E-mail _____

Appendix 5 Temporary Insurance Agreement and Receipt ("Agreement")

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.

Mutual of Omaha Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901

Policy form (rider) applied for _____

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for the Proposed Insured, subject to the following conditions and limitations:

1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Proposed Insured lives, on the latest of these dates:
- **(a)** The date the above sum is received; or
- **(b)** The date the application is signed by the Producer(s) and Proposed Insured; or
- **(c)** The date this Agreement is signed by the Producer(s) and Proposed Insured.

2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Proposed Insured lives, on the earliest of the following dates:
- **(a)** 90 days from the date of this Agreement; or
- **(b)** the date that insurance takes effect under the policy applied for; or
- **(c)** the date a policy, other than as applied for, is offered by a Producer to the Proposed Insured; or
- **(d)** the date Mutual of Omaha Insurance Company mails the premium refund and letter informing the Proposed Insured that the policy applied for will not be issued; or
- **(e)** the date Mutual of Omaha Insurance Company mails notice of termination of this Agreement to the Proposed Insured.

3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series; **but in no event shall benefits be payable to a Proposed Insured under this Agreement for more than one year after the date a claim begins under this Agreement.**

4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5 **In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.**

6 If any of the answers to the questions on the application given by the Proposed Insured are incorrect or misleading, then this Agreement is void as to that Proposed Insured and never went into effect.

This Agreement does not limit Mutual of Omaha Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of a Proposed Insured is rejected by Mutual of Omaha Insurance Company, the amount paid with the application for that Proposed Insured will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____
Month Year City State Zip Code

_____ _____ _____
Producer's Signature Proposed Insured's Signature Please print name

_____
Producer's Signature

Company Copy

Appendix 5 Temporary Insurance Agreement and Receipt ("Agreement")

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.

Mutual of Omaha Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901

Policy form (rider) applied for _____

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for the Proposed Insured, subject to the following conditions and limitations:

1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Proposed Insured lives, on the latest of these dates:
- **(a)** The date the above sum is received; or
- **(b)** The date the application is signed by the Producer(s) and Proposed Insured; or
- **(c)** The date this Agreement is signed by the Producer(s) and Proposed Insured.

2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Proposed Insured lives, on the earliest of the following dates:
- **(a)** 90 days from the date of this Agreement; or
- **(b)** the date that insurance takes effect under the policy applied for; or
- **(c)** the date a policy, other than as applied for, is offered by a Producer to the Proposed Insured; or
- **(d)** the date Mutual of Omaha Insurance Company mails the premium refund and letter informing the Proposed Insured that the policy applied for will not be issued; or
- **(e)** the date Mutual of Omaha Insurance Company mails notice of termination of this Agreement to the Proposed Insured.

3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series; **but in no event shall benefits be payable to a Proposed Insured under this Agreement for more than one year after the date a claim begins under this Agreement.**

4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5 **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**

6 If any of the answers to the questions on the application given by the Proposed Insured are incorrect or misleading, then this Agreement is void as to that Proposed Insured and never went into effect.

This Agreement does not limit Mutual of Omaha Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of a Proposed Insured is rejected by Mutual of Omaha Insurance Company, the amount paid with the application for that Proposed Insured will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____
Month Year City State Zip Code

_____ _____ _____
Producer's Signature Proposed Insured's Signature Please print name

_____
Producer's Signature

Proposed Insured's Copy

Appendix 6 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, LONG-TERM CARE SERVICE OFFICE, P.O. BOX 64901, ST. PAUL, MN 55164-0901.

Remove Notice and Give to Proposed Insured

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

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

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Agent
I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
Agent's Signature

_____
Typed Name and Address of Agent

The above Notice to Applicant was delivered to me on:

_____
Date

_____
Applicant's Signature

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

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

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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_____
Agent's Signature

_____
Typed Name and Address of Agent

The above Notice to Applicant was delivered to me on:

_____
Date

_____
Applicant's Signature

MUTUAL OF OMAHA INSURANCE COMPANY
HOME OFFICE: OMAHA, NEBRASKA

Summary of Determination for
Substantially Greater Benefits

The following types of coverage or benefit increases for Long-Term Care **external replacements** can result in payment of first year compensation. This form **must** be returned to the Home Office with the completed application.

Increase in Coverage	**Check all changes that apply (✔)**
1. Addition of Inflation Protection	
2. Addition of Return of Premium	
3. Addition of Shortened Benefit Period	
4. Addition of Home Health Care	
5. Addition of Confined Care	
6. Change from non-tax qualified to tax qualified plan	
7. At least a 20% increase in daily benefit amount	
8. Increase in benefit period	
9. Decrease in Elimination Period; or	
10. Change from non-partnership to partnership plan (applicable in Indiana only)	

Increase in Benefit per Dollar	**Check all changes that apply (✔)**
1. No change in benefits, but at least 10% lower premiums; or	
2. Fewer benefits, but at least 10% lower premiums	

_____
Agent's Signature

_____
Printed Name and Address of Agent

If this form is **not** completed and returned with the application, external replacements will be compensated at the renewal commission rate.

This information is for use with Long-Term Care policy forms in **Indiana, North Carolina** and **South Dakota** only.

Long-Term Care Insurance Personal Worksheet

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

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

The purpose of this worksheet is to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are considering will be $_____ per month, or $_____ per year.

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums

The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2004. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	Rate History
NH23/NH24	1988-1993	No Rate Increase
LTC1/LTM1	1992-1997	No Rate Increase
LT50	1997-2004	No Rate Increase
NHA/LTA/HCA	1998-2004	23% overall rate increase 2003
LTC04	2004-Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals would vary by state.

*Or state equivalent.

Questions Related to Your Income

How will you pay each year's premium? (Check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

☐ Under $10,000 ☐ $10-15,999 ☐ $16-29,999 ☐ $30-50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years? (Check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of nursing home care in 2002 was $61,320, but this figure varies across the country. In ten years the national average annual cost would be about $99,884 if costs increase 5% annually.

What elimination period are you considering? Number of days _____
Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (Check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (Check one)

☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Check one

☐ The answers to the questions above describe my financial situation.	☐ I choose not to complete this information.

Signed: _____ _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent/Producer) (Date)

Agent's/Producer's Printed Name: _____

My agent/producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Long-Term Care Insurance coverage.

Signed: _____ _____
(Applicant) (Date)

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

1. **Premium Rate**: Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is $_____

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

   The premium rates for this policy may change. Any change will be effective on the next billing date after the company has provided you at least 60 days written notice before we change premiums.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

M19775_0303

Conversion Offer

I understand that I have been given the opportunity to exchange my Mutual of Omaha non-tax qualified Long-Term Care policy at any time during the life of the policy (if issued) without evidence of insurability. If my non-tax qualifed plan includes the Return of Premium Rider, it will be terminated once the policy is exchanged.

I also understand that **if** my current non-tax qualified Long-Term Care policy does not contain inflation and/or nonforfeiture benefits:

1. then the tax qualified plan for which I'm requesting conversion will not have such benefits; or
2. if I want inflation and/or nonforfeiture benefits under the tax qualified plan: (a) I need to contact my Mutual of Omaha representative in order to apply for coverage; (b) eligibility will be based upon my current health; and (c) premiums will be based upon my current age.

Applicant Signature: _____ Date: _____

Agent Signature: _____ Date: _____

Agent Copy

M21005_0803

Conversion Offer

I understand that **if** my current non-tax qualified Long-Term Care policy does not contain inflation and/or nonforfeiture benefits:

1. then the tax qualified plan for which I'm requesting conversion will not have such benefits; or
2. if I want inflation and/or nonforfeiture benefits under the tax qualified plan: (a) I need to contact my Mutual of Omaha representative in order to apply for coverage; (b) eligibility will be based upon my current health; and (c) premiums will be based upon my current age.

Applicant Signature: _____ Date: _____

Agent Signature: _____ Date: _____

Customer Copy

M21005_0803