Mutual of Omaha Insurance Company
P.O. Box 3608 Omaha, Nebraska 68103-3608

Application Submission Checklist To Mutual of Omaha For Medicare Supplement Coverage – MO, ND

THIS APPLICATION MUST BE USED TO WRITE MUTUAL OF OMAHA MEDICARE SUPPLEMENT PRODUCTS

☐ **Application**

1. Complete "Plan Information" Box
2. Refer to the Outline of Coverage for policy forms.
3. Answer all questions in full.
4. Sign and Date in all places indicated.
5. Be sure to leave all applicable forms with the proposed insured.
6. See reverse side of this page for additional detailed information.

☐ **Collect Premium Amount**

- The full modal premium is collected at the time of application.
- Calculate the premium based on age at time of application.
- Tobacco rates do not apply during Open Enrollment or Guarantee Issue situations.

☐ **Provide Client with Buyer's Guide**

☐ **Provide Client with Outline of Coverage**

☐ **Complete Producer Information page**

☐ **Complete Bank Service Plan (BSP) Authorization (if applicable)**

☐ **Provide Client with Official Receipt signed by agent**

☐ **Complete Replacement Notice (M18362_0605) and leave a copy with the applicant (if applicable)**

Please provide additional information and comments in the space provided on the application.

Note: An interviewer may call to verify/confirm the information provided on the application.

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.

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.

1. Application

Agent Completes in Full: (please print)

“Plan Information” Box

- Policy Form
- Riders (MN & WI only)
- Requested Effective Date
- Premium Collected (Amount)
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
  *Direct Monthly billing not available

Part I “General Information”–

- Residence address and ZIP code are indicated. Alternate address for billing is indicated (when applicable).
- The applicant’s age is the age at time of application.
- Social Security number is correctly indicated on application.

Part II “Existing Coverage Information”–

- Medicare card number (Health Insurance Claim Number) is correctly indicated for applicants already covered by Medicare. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent **must** provide this number by calling 1-877-617-5587 once it is received.
- If the applicant is not covered by Medicare, indicate “Eligibility Date” and “Date of Enrollment.”
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
  – Name of Company
  – Policy/Certificate Number
  – Plan
  – Issue Date
  – Termination/Disenrollment Date
  – Kind of Policy

Note: an interviewer may call to verify/confirm the information provided on the application.

2. Administrative Forms

Trust Affiliation

- Be sure to include signatures and date.

Producer Information

- Be sure to include your Social Security number and commission code.
  This is necessary information for the underwriting process and commission payment.
- Include your telephone number and email address - if applicable.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company (BSP) – complete if applicable

- Payments will be taken monthly, on the 1st or the 15th of the month. You do not need to provide a voided check, unless the premium is to be paid from a separate account. Checking account information will be taken from the accompanying premium check.

Receipt

- Detach and leave with applicant.

Replacement Notice – complete if applicable

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

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Mutual *of* Omaha Insurance Company

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:
PLAN INFORMATION (to be completed by **Producer**)		
Policy Form	Requested Effective Date:	
Spouse applying for coverage (different application)? Yes ☐ No ☐		
Premium Collected $	Initial Mode **A, S, Q or B**	
Renewal $	Renewal Mode **A, S, Q or B** (monthly not allowed)	

Application To Mutual of Omaha Insurance Company For Medicare Supplement Coverage

PART I. GENERAL INFORMATION

1. Print Name____________________ (Title) (First) (Middle) (Last) Home Phone No.(______)____________ (Area Code)
2. Residence Address____________________ (No. and Street and Apt. No.) (City) (State) (ZIP Code)
3. Mailing Address____________________ (No. and Street and Apt. No.) (City) (State) (ZIP Code)
4. Birth Date________________ (Mo. Day Yr.) Age ________ *(current age)* Sex: M ☐ F ☐ Height:_______Ft. _______ In. Weight __________Lbs.
5. Social Security No.________________ E-mail Address: ____________________
6. Have you received a copy of the *Guide to Health Insurance for People with Medicare* and the Outline of Coverage?... Yes ☐ No ☐
7. Have you used tobacco in any form in the past 12 months?.......... Yes ☐ No ☐

PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

To the best of your knowledge:

1. Are you covered under Medicare? .... Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐
   If "Yes," give your Medicare card number. __________________ If "No," when will you become eligible? __________________ (Mo. Day Yr.)
2. Did you turn age 65 in the last 6 months? .... Yes ☐ No ☐
3. Did you enroll in Medicare Part B in the last 6 months? .... Yes ☐ No ☐
   If "Yes," indicate your effective date._____________________ (Mo. Day Yr.) If "No," indicate date you plan to enroll. __________________ (Mo. Day Yr.)
4. Are you applying during a guaranteed issue period?.......... Yes ☐ No ☐
   (**NOTE**: If the answer above is "Yes" please attach proof of eligibility.)

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

5. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _______/_____/________END ______/_____/_______
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?.......... Yes ☐ No ☐
   (c) **If yes, have you received a copy of the replacement notice?** .... Yes ☐ No ☐
   (d) Reason for termination/disenrollment? ____________________
   (e) Planned date of termination/disenrollment _______/_____/________
   (f) Was this your first time in this type of Medicare plan?.......... Yes ☐ No ☐
   (g) Did you drop a Medicare Supplement policy to enroll in this Medicare plan? .... Yes ☐ No ☐
6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) .... Yes ☐ No ☐
   (a) If so, with what company and what kind of policy?

Name of Company	Kind of Policy

(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.
START ____/____/______ END ______/____/_______

(c) Reason for termination/disenrollment? ____

(d) Date of termination/disenrollment ______/____/_______

7. (a) Do you have another Medicare Supplement insurance policy in force?.. Yes ☐ No ☐

(b) If so, with what company, and what plan do you have?

Name of Company	Policy/Certificate Number	Plan	Issue Date

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?................................ Yes ☐ No ☐

(d) If "Yes," indicate termination date. ____________ (Mo. Day Yr.) **Have you received a copy of the Replacement Notice?**..... Yes ☐ No ☐

8. Are you covered for medical assistance through the state Medicaid program? [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.] ...... Yes ☐ No ☐

If yes, (a) Will Medicaid pay your premiums for this Medicare Supplement policy? .... Yes ☐ No ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? .... Yes ☐ No ☐

9. Producers shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

(b) List policies sold in the past five (5) years which are no longer in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

PART III. HEALTH /MEDICAL QUESTIONS (COMPLETE IN FULL)

1. **If the answer is "Yes" to any of the following health questions (a)-(n), you are not eligible for coverage. (If you are applying for coverage during open enrollment or during a guaranteed issue period, do not answer questions 1 & 2 in section III.)**

	Yes	No
(a) Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	☐	☐
(b) Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐	☐
(c) Have you been diagnosed with Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis?	☐	☐
(d) Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder?	☐	☐
(e) Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
(f) Do you have diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (**including** high blood pressure) or kidney disease?	☐	☐
(g) Do you have diabetes that has ever required more than 50 units of insulin daily?	☐	☐
(h) Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse; cirrhosis; mental or nervous disorder requiring psychiatric care; or have you had any amputation caused by disease?	☐	☐
(i) Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure); peripheral vascular disease; congestive heart failure or enlarged heart; stroke; transient ischemic attacks (TIA), or heart rhythm disorders?	☐	☐
(j) Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis, or have you been advised to have a joint replacement?	☐	☐
(k) Have you been advised by a physician that surgery may be required within the next twelve months for cataracts?	☐	☐
(l) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐	☐
(m) Have you been hospital confined three or more times in the last two years?	☐	☐
(n) Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐	☐

2. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? .... Yes ☐ No ☐
If "Yes," please list the drug and the condition. (Use page 4 of application, if more space is necessary.)

Medication Name (copy off pharmacy label)	Date **Originally** Prescribed	Frequency and Dosage	Diagnosis/Condition

I represent that my answers and statements are true and complete and agree that no insurance will be effective unless a policy is issued.

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

(a) You do not need more than one Medicare Supplement policy.

(b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.

(c) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(d) If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(e) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Dated at ___________________________, on ___________________, _____ ____
(City) (State) (Month) (Day) (Year) (Signature of Applicant)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_________________________	_________________________	_________________________
(Signature of Licensed Producer) PRODUCER STAMP	(Signature of Licensed Producer) PRODUCER STAMP	(Signature of Licensed Producer) PRODUCER STAMP

ADDITIONAL INFORMATION: PART III - CON'T. HEALTH /MEDICAL QUESTIONS - Question #2.

Medication Name (copy off pharmacy label)	Date **Originally** Prescribed	Frequency and Dosage	Diagnosis/Condition

SECTION FOR ADDITIONAL COMMENTS:

MUTUAL of OMAHA INSURANCE COMPANY • P.O. Box 3608 • Omaha, Nebraska 68103-3608

Trust Affiliation

(Complete only if M500, series are being sold — i.e., M500, M501, M502 or state special version)

Mutual of Omaha Insurance Company and/or its Affiliates (Insurer) are authorized to issue insurance plans to the Direct Marketer's Insurance Trust (hereinafter called Trust). For the sole purpose of obtaining the said insurance plan or plans issued to the Trust, the Proposed Insured (named below) hereby affiliates with the Trust.

______________________________ Proposed Insured Signature

______________________________ Mutual of Omaha Insurance Company Representative

______________________________ Date

______________________________ Office

Producer(s) Information

Producer Name: ______________________ Social Security No. ______________

Comm. % Share: _____ Producer Phone No. (____)__________ Commission Code: ____________

Producer E-mail Address: ______________ @ ______________________

Producer Name: ______________________ Social Security No. ______________

Comm. % Share: _____ Producer Phone No. (____)__________ Commission Code: ____________

Producer E-mail Address: ______________ @ ______________________

Producer Name: ______________________ Social Security No. ______________

Comm. % Share: _____ Producer Phone No. (____)__________ Commission Code: ____________

Producer E-mail Address: ______________ @ ______________________

(**Note**: Producers must be under the same commission code to share or split commissions.)

Producer To Complete Only If Premium Is To Be Paid With A Business Check

Is the applicant:	Yes	No
(a) unemployed?	☐	☐
(b) employed, but not working for the business that is paying the premium?	☐	☐
(c) the business owner or spouse of the business owner?	☐	☐

If (a), (b), or (c) is "Yes," the premium can be paid with a business check.

Mutual *of* Omaha Insurance Company

P.O. Box 3608 Omaha, Nebraska 68103-3608

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company (BSP)

ATTENTION: PLEASE READ CAREFULLY

Complete the Bank Service Plan below and submit with the application if premium payments are to be withdrawn from the applicant's bank account.

How To Sign up for the Bank Service Plan

1. Complete the form, making sure to write your name as shown on your checking amount.
2. Include your check for the first month's payment with your completed form. We'll use the account number on your check to put your monthly Bank Service Plan payments into effect. So it's important your check is from the account you want your payments withdrawn from.

Complete the following only if you are adding the above coverages to an existing BSP account.

______________________________ Insured Under Existing BSP

______________________________ Existing BSP Policy Number

Specify Date of Withdrawals: ☐ 1st of the Month ☐ 15th of the Month

Important! Fill in and return if you want your bank to make monthly insurance payments for you.

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY, Omaha, Nebraska. As a convenience to me, I authorize you to pay and charge to my account any checks, drafts or preauthorized electronic fund transfer made upon my account by, and payable to the order of, Mutual of Omaha Insurance Company. I agree that your rights with respect to each charge will be the same as if it were personally executed by me. This authorization is to remain in effect until I give you, my financial institution, at least three business days' notice to revoke it, provided, however, if notice is given orally, then you may require a written confirmation from me within 14 days after the oral notification.

__________ Date X______________________________ Authorized Signature as Shown on Account

__________ Date X______________________________ Joint Account or Other Authorized Signature

Your premiums will be withdrawn monthly from your checking account on the date you've checked above.

Mutual of Omaha Insurance Company
P.O. Box 3608 Omaha, Nebraska 68103-3608

Official Receipt

Cash or Check Application

All premiums must be made payable to Mutual of Omaha Insurance Company

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

Received of ____ this ____

day of ___________________, ________ an application for a Form _______________ Policy and Riders ______________

_________________________________ and Cash or Check for ____Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent ____

NOTICE TO APPLICANT: Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.

Complete Receipt in full and leave with applicant at time of application.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy or certificate to be issued by Mutual of Omaha Insurance Company. Your new policy or certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy or certificate.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy or certificate will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy or certificate is being purchased for the following reason(s) (check one):

____ Additional benefits
____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
____ Other (please specify) ______________________________

____
____
____

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and 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 or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy or certificate until you have received your new policy or certificate and are sure that you want to keep it.

____
(Signature of Agent, Broker or Other Representative)*

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

______________________________ ______________________
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

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____ No change in benefits, but lower premiums
____ Fewer benefits and lower premiums
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
____ Other (please specify) ____
____
____
____

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(Signature of Agent, Broker or Other Representative)*

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

______________________________________ ______________________
(Applicant's Signature) (Date)

*Signature not required for direct response sales.