This is a SAMPLE only, not to be used for applying for coverage. Contact HealthChoice for more information 800--833-5823 or info@healthChoice.com

MUTUAL OF OMAHA INSURANCE COMPANY

MutualCare® Solutions

For Wisconsin State & County Employees and Retirees

Application for Long-Term Care Insurance

WISCONSIN

Application Package Contains:

<table>
<tr><th colspan="4">Required Forms to be Submitted</th></tr>
<tr><td>Long-Term Care Personal Worksheet</td><td colspan="3">Must complete, sign and submit with application. This worksheet helps determine whether a Long-Term Care policy is suitable.</td></tr>
<tr><td>Application</td><td colspan="3">1. Sections A-H must be answered in full. Notes: Any changes must be initialed. Check height/weight build chart to ensure client eligibility. If the applicant wishes to provide an alternate mailing address other than the legal residence address shown on the application, please contact the service office at 1-877-894-2478.
2. Choose to complete either Section I or J.
3. Section K - Enter the amount of premium and billing mode. Notes: At least two months premium must be submitted with monthly mode. If another mode is selected, submit applicable premium for that mode. There is no policy fee.
4. Sections L-M must be answered in full.</td></tr>
<tr><td>Authorization to Disclose Personal Information (HIPAA)</td><td>Producer Statement</td><td>Conditional Receipt (applicable if initial payment provided with app)</td><td>Replacement Notice (if applicable)</td></tr>
<tr><td colspan="2">Summary of Determination for Substantially Greater Benefits (if applicable)</td><td colspan="2">Authorization for Release of Information to My Insurance Agent and/or Agency (if applicable)</td></tr>
</table>

<table>
<tr><th colspan="4">Required Forms to be Left with Applicant(s)</th></tr>
<tr><td>Conditional Receipt (applicable if initial payment provided with app)</td><td>Replacement Notice (if applicable)</td><td>MIB Inc. Pre-Notice</td><td>Things You Should Know Before You Buy Long-Term Care Insurance</td></tr>
<tr><td>Long-Term Care Insurance Potential Rate Increase Disclosure Form</td><td>Partnership Notices</td><td>Authorization for Release of Information to My Insurance Agent and/or Agency (if applicable)</td><td>Outline of Coverage</td></tr>
</table>

Not Contained within this Application Package:

<table>
<tr><th colspan="2">Required Forms to be Left with Applicant(s) that are Not Included within this Package</th></tr>
<tr><td>LTC Shopper's Guide (Not included within this package. Please provide in addition.)</td><td>Guide to Medicare for People Age 65 and Older (Not included within this package. If applicable, please provide in addition.)</td></tr>
</table>

Inform your client(s) that we will conduct a telephone interview or face to face interview. Provide them a copy of "***Preparing for the Personal Health Interview***" included as last page of this package.

Unanswered questions on the application or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If a ***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 D***, he/she is ineligible for coverage.

If after review of our application and underwriting guide you are unable to determine how underwriting will handle a case, you may obtain additional guidance by calling 1-800-551-2059 or by sending an e-mail to ltcunderwriting@mutualofomaha.com. Please do not call or e-mail until you have reviewed both the application and our underwriting guide to learn how we will handle the specific condition(s). To discuss a potential client the underwriter will need to know the client's age, height and weight, tobacco status for the past two years, all medications, all health conditions, and whether or not the client has previously been declined for coverage, and if so, why.

May be beneficial to send include a copy of illustration with the application.

Submit the fully completed application, and applicable completed forms to:

For regular mail submission:	**For overnight submission:**
Long-Term Care Service Office	Long-Term Care Service Office
P.O. Box 64901	7805 Hudson Rd., Ste. 180
St. Paul, MN 55164-0901	Woodbury, MN 55125-1591

For Fax submission, you, the producer, must:

- Use the **maximum resolution** to ensure the readability of the application/forms;
- Fax to **1-888-539-4672** and verify that the correct fax number is dialed to protect the privacy of the information contained in the application/forms;
- If initial premium by check, send a **copy of the initial premium check** as the last page of the fax;
- If initial premium by check, **retain the initial premium check** collected with the application until a policy number has been assigned. A policy number is usually assigned within three workdays and can be found on Sales Professional Access status reports. Then write the policy number on the check and mail the check to: Mutual of Omaha, P.O. Box 30154, Omaha, NE 68103-1254; and
- **Retain the original application/forms** in a secured location for at least 90 days to ensure we get through the underwriting process and avoid any legibility issues. Do not also send a paper copy of a faxed application/forms.

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Long-Term Care Insurance Personal Worksheet

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.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) ICC13-LTC13
Type of Policy: Guaranteed Renewable

Applicant A

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

Applicant B

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

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. Once your policy is paid up, the company cannot raise your rates.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2013. The company has not raised its premium rates on this policy form, but has on similar policy forms in the last 10 years. 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	1987 - 1993	No Rate Increase
LTC1/LTM1	1992 - 1997	No Rate Increase
NHA/LTA/HCA	1998 - 2004	28% overall rate increase 2003-2007
LT50/NH50/NHA/LTA/HCA	1997 - 2004	24% overall rate increase 2011
LT50/NH50/NHA/LTA/HCA	1997 - 2004	7% overall rate increase 2012
LT50/NH50/NHA/LTA/HCA	1997 - 2004	18% overall rate increase 2015
LT50/NH50/NHA/LTA/HCA	1997 - 2004	10% overall rate increase 2016
LTC04I	2004 - 2015	19% overall rate increase 2013
LTC04G	2004 - 2014	22% overall rate increase 2013 (for issues prior to 8/1/2007)
LTC04I7	2006 - 2009	No Rate Increase
LTC09M	2009 - Present	No Rate Increase
ICC13-LTC13	2013 - Present	No Rate Increase

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

*Or state equivalent.

Questions Related to Your Income

Applicant A

1. How will you pay each year's premium?
   - ☐ From my Income
   - ☐ From my Savings/Investments
   - ☐ My Family will Pay

2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
   - ☐ Yes
   - ☐ No - *If you have not considered this possibility, please do not proceed with the application until doing so.*

3. What is your annual income? (Check one)
   - ☐ Under $10,000 ☐ $10,000-$20,000
   - ☐ $20,001-$30,000 ☐ $30,001-$50,000
   - ☐ Over $50,000

4. How do you expect your income to change over the next 10 years? (Check one)
   - ☐ No Change ☐ Increase ☐ Decrease

Applicant B

1. How will you pay each year's premium?
   - ☐ From my Income
   - ☐ From my Savings/Investments
   - ☐ My Family will Pay

2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
   - ☐ Yes
   - ☐ No - *If you have not considered this possibility, please do not proceed with the application until doing so.*

3. What is your annual income? (Check one)
   - ☐ Under $10,000 ☐ $10,000-$20,000
   - ☐ $20,001-$30,000 ☐ $30,001-$50,000
   - ☐ Over $50,000

4. 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.

Applicant A

5. 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

Applicant B

5. 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 2018 was $104,137, but this figure varies across the country. In ten years the national average annual cost would be about $169,700 if costs increase 5% annually.

Applicant A

6. What elimination period are you considering?

   Number of days ________

   Approximate cost $______ for that period of care.

Applicant B

6. What elimination period are you considering?

   Number of days ________

   Approximate cost $______ for that period of care.

Multiply the number of days by the approximate daily cost of care.

Applicant A

7. 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

Applicant B

7. 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

Applicant A

1. 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
   - ☐ $30,001-$50,000 ☐ Over $50,000

2. How do you expect your assets to change over the next 10 years? (Check one)
   - ☐ Stay about the same ☐ Increase ☐ Decrease

Applicant B

1. 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
   - ☐ $30,001-$50,000 ☐ Over $50,000

2. How do you expect your assets to change over the next 10 years? (Check one)
   - ☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets, not counting your home, are less than $50,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Applicant A

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

Applicant B

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

Applicant A

☐ ◀ **THIS BOX MUST BE CHECKED**
I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

X ______________________ ______
Signature of Applicant A Date

Applicant B

☐ ◀ **THIS BOX MUST BE CHECKED**
I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

X ______________________ ______
Signature of Applicant B Date

I explained to the applicant(s) the importance of completing this information.

____
Printed Name of Producer

X ______________________ ______
Signature of Producer Date

Authorization to Proceed when Income less than $20,000 and Assets less than $50,000

Applicant A

My 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.

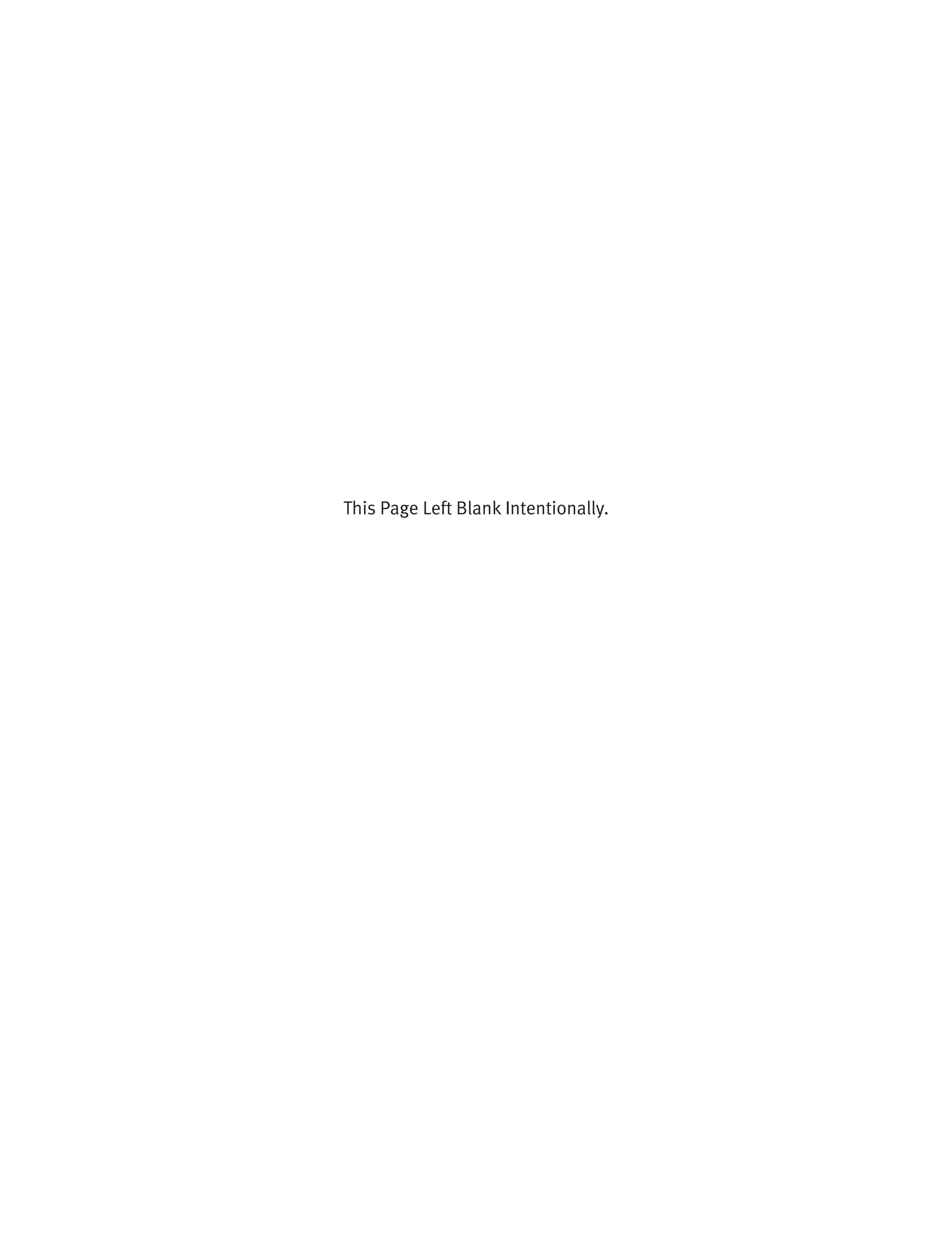
X ______________________ ______
Signature of Applicant A Date

Applicant B

My 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.

X ______________________ ______
Signature of Applicant B Date

The company may contact you to verify your answers.



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Mutual of Omaha Insurance Company

Mutual of Omaha Plaza, Omaha, NE 68175

Mutual of Omaha

Submit Application To: Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901
Overnight Submission: Long-Term Care Service Office, 7805 Hudson Rd., Ste. 180, Woodbury, MN 55125-1591

☐ **New Business**
☐ **Reinstatement**

☐ **Sponsored/Association Group**
☐ **Common Employer**
☐ **Producer**

Each Applicant acknowledges and agrees that if there is more than one Applicant on this application, all information provided may be reviewed or shared with the other Applicant. A completed and signed application will become part of each applicant's policy.

Section A GENERAL INFORMATION

Applicant A

1 Name:

Last Name

First Name Middle Initial

2 Legal Residence Address:

Number, Street, Apartment Number

City, State, ZIP Code

3 Contact Information:

( ) – ( ) –

Daytime Phone Number Evening Phone Number

: a.m. : p.m.

Best Time to Call Within a 2-Hour Window (i.e., if 5p.m. is indicated, contact window is from 5:00-7:00 p.m.)

Email Address

4 Social Security Number:

☐☐☐–☐☐–☐☐☐☐

5 Birth Date, Age and Sex:

Month / Day / Year Age

☐ Male ☐ Female

6 Occupation and Duties:

Occupation

Occupational Duties

Applicant B

1 Name:

Last Name

First Name Middle Initial

2 Legal Residence Address *(If Different than Applicant A)*:

Number, Street, Apartment Number

City, State, ZIP Code

3 Contact Information *(If Different than Applicant A)*:

( ) – ( ) –

Daytime Phone Number Evening Phone Number

: a.m. : p.m.

Best Time to Call Within a 2-Hour Window (i.e., if 5p.m. is indicated, contact window is from 5:00-7:00 p.m.)

Email Address

4 Social Security Number:

☐☐☐–☐☐–☐☐☐☐

5 Birth Date, Age and Sex:

Month / Day / Year Age

☐ Male ☐ Female

6 Occupation and Duties:

Occupation

Occupational Duties

Section A (continued) GENERAL INFORMATION

Applicant A

7 Citizenship Status (check one):

☐ U.S. Citizen, or

☐ Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years. If checked, please complete Foreign Travel Questionnaire.

☐ Neither, you are not eligible for this coverage.

8 Beneficiary:

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to You

Applicant B

7 Citizenship Status (check one):

☐ U.S. Citizen, or

☐ Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years. If checked, please complete Foreign Travel Questionnaire.

☐ Neither, you are not eligible for this coverage.

8 Beneficiary *(If Different than Applicant A)*:

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to You

Section B ALLOWANCES

You may be eligible for allowances based on your answers to the following questions in this Section B.	**Applicant A** Yes	No	**Applicant B** Yes	No
1 Do you have a Partner?*	☐	☐	☐	☐
If **"Yes,"** complete (a) and (b):				
(a) Is he/she also applying for this coverage?	☐	☐	☐	☐
If **"Yes,"** provide full name only if not applying on this application				
(b) Does he/she have an existing Mutual of Omaha Insurance Company Long-Term Care policy/certificate?	☐	☐	☐	☐
If **"Yes,"** provide existing long-term care policy/certificate number(s)				
2 Are you or your Partner* a member of a Sponsored/Association Group endorsing this long-term care product?	☐	☐	☐	☐
3 Are you eligible for an employer allowance?	☐	☐	☐	☐

Question 2 — If **"Yes,"** provide:

Group Number 0

Full Name of Organization

Name and Relationship to Member

Membership Number

Membership Effective Date Month / Year

Question 3 — If **"Yes,"** provide:

Group Number

Group Name

Employment Date

*Partner means the one person who is: (a) your spouse to whom you are legally married; (b) your registered domestic partner or civil union partner; or (c) an adult person who: 1. shares a serious and committed personal relationship with you that is intended to be lifelong; 2. has shared a common permanent residence with you on a continuous basis for the most recent three years; 3. is not married, a domestic partner, a civil union partner, or in a committed personal relationship to anyone else; and 4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

Section C REPLACEMENT COVERAGE

Provide replacement coverage information.

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Do you currently have another long-term care insurance policy/certificate in force (including health care service contracts or health maintenance organization contracts)?	☐	☐	☐	☐
2	Did you have another long-term care insurance policy/certificate in force during the last 12 months?	☐	☐	☐	☐
3	Do you intend to replace other long-term care coverage or any of your medical or health insurance coverage with this policy? If **"Yes,"** please read and sign the Notice to Applicant Regarding Replacement form included with this application.	☐	☐	☐	☐
4	**Question to be answered by the Producer:** Have you, **the Producer**, sold any health insurance, including long-term care policies, to Applicant A or Applicant B which: are still in force; or were sold in the last five years but are no longer in force?	☐	☐	☐	☐

If any question 1-4 was answered "Yes," in the above Section C, please provide details in C5 below.
(Attach additional signed page(s) if more space is needed.)

5

Applicant	Company Name/Address	Policy/ Certificate #	Plan Type*	Daily or Monthly Benefit	Status of Policy/Certificate	Annual Premium	To be Replaced by this Coverage	Sold by this Producer
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date __/__/__	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date __/__/__	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date __/__/__	$	☐ Yes ☐ No	☐ Yes ☐ No

*Provide Plan Type abbreviation key: LTC=Long-Term Care, MS=Medicare Supplement, MM=Major Medical, OH=Other Health

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
6	Have you ever been declined, rated, or denied reinstatement for long-term care insurance? If **"Yes,"** provide details below. (Attach additional signed page(s) if more space is needed.)	☐	☐	☐	☐

Applicant	Company Name(s)	When	Why
☐ A ☐ B			
☐ A ☐ B			

ICC13-MA6012 (WI)

Section D HEALTH INSURABILITY QUESTIONS

If you answer "Yes" to any of the questions in this Section D, we are unable to accept this application or offer you Long-Term Care Insurance. Do not continue.

	Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1 Are you age 65 or older and has it been more than 2 years since you have had a doctor's visit which included a head to toe physical examination with blood work (basic metabolic chemistry panel)?	☐	☐	☐	☐
2 Do you currently use any of the following? • quad cane • walker • wheelchair • electric scooter • stairlift • hospital bed • respirator • nebulizer • oxygen (including supplemental CPAP use)	☐	☐	☐	☐
3 Within the past 6 months have you been confined to, used, or been advised to have, any of the following? • residential care, assisted living or adult day care facility services • nursing home or home health care services	☐	☐	☐	☐
4 Do you require the assistance or supervision of another person or a device of any kind for any of the following? • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐	☐	☐
5 Have you ever had, been diagnosed as having, or received medical advice or medical care from a physician or health care provider for any of the following? • Alzheimer's Disease • Huntington's Chorea • Parkinson's Disease • Dementia • Chronic Hepatitis • Systemic Lupus • Memory Loss • Cirrhosis • Multiple Sclerosis (MS) • Mild Cognitive Impairment • Hydrocephalus • Muscular Dystrophy • Organic Brain Syndrome • Multiple Myeloma • Myasthenia Gravis • Schizophrenia • Psychosis • Scleroderma • Mental Retardation • Organ Transplant • Paralysis • Connective Tissue Disease • Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease) • Kidney Failure or received Dialysis • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, 2 or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy or history of a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year	☐	☐	☐	☐
6 Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic)?	☐	☐	☐	☐
7 Do you currently qualify for payment or are you receiving payment benefits under Medicaid (not Medicare), disability income plan, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐	☐	☐

Section E PRIMARY PHYSICIAN INFORMATION AND MEDICATION

Applicant A

1 **Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years:**

Primary Name

Address

City, State, ZIP Code

Phone Number

2 **Date of Last Visit:**

Month / Year

3 **Why did you last see this physician?**

4 **Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:**

Month / Year

5 **Medication:**

Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently?

☐ Yes, details provided on next page.

☐ No

Applicant B

1 **Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years *(If Different than Applicant A)*:**

Primary Name

Address

City, State, ZIP Code

Phone Number

2 **Date of Last Visit:**

Month / Year

3 **Why did you last see this physician?**

4 **Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:**

Month / Year

5 **Medication:**

Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently?

☐ Yes, details provided on next page.

☐ No

If "Yes," to question 5, please list on the next page all the medication name(s) using pharmacy label, dosage, how often you take, how long have you taken, prescribed by, why you take, when and why for any dosage increase or decrease. (Attach additional signed page(s) if more space is needed.)

Section F MEDICATION INFORMATION

Please list all over-the-counter or prescription medications you have taken in the past 12 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Applicant B

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Section G — ADDITIONAL HEALTH QUESTIONS

	Question	Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Have you ever received any advice, treatment, consultation or diagnosis from a physician or health care provider for any of the following conditions? The following conditions require a stability period ranging from 3 months to 5 years to be eligible for coverage. Refer to our Underwriting Guidelines to insure the stability period has been met.				
	(a) Vision Disorder	☐	☐	☐	☐
	(b) Dizziness/Vertigo or Fainting	☐	☐	☐	☐
	(c) Head Injury, Nerve Damage or other Neurological Disease/Disorder	☐	☐	☐	☐
	(d) Fibromyalgia, Weakness or Fatigue	☐	☐	☐	☐
	(e) Stroke, Transient Ischemic Attack, Aneurysm, Carotid or Circulatory Disease/Disorder	☐	☐	☐	☐
	(f) Seizure, Epilepsy or Tremors	☐	☐	☐	☐
	(g) Depression, Anxiety or other Mental Disorder	☐	☐	☐	☐
	(h) Lung Disease/Disorder	☐	☐	☐	☐
	(i) Heart Rhythm, Heart Valve, Coronary Artery or Heart Disease/Disorder	☐	☐	☐	☐
	(j) High Blood Pressure	☐	☐	☐	☐
	(k) Anemia, Blood Clotting or Blood Disease/Disorder	☐	☐	☐	☐
	(l) Arthritis, Broken Bone, Back, Spinal Stenosis, Scoliosis, Bone or Joint Disorder	☐	☐	☐	☐
	(m) Chronic Pain, Amputation or Polymyalgia Rheumatica	☐	☐	☐	☐
	(n) Osteoporosis or Osteopenia	☐	☐	☐	☐
	(o) Balance Disorder, Difficulty Walking or Falls	☐	☐	☐	☐
	(p) Cancer, Leukemia or Lymphoma	☐	☐	☐	☐
	(q) Diabetes	☐	☐	☐	☐
	(r) Immune System Disease/Disorder	☐	☐	☐	☐
	(s) Kidney Disease/Disorder	☐	☐	☐	☐
	(t) Hepatitis or Liver Disease/Disorder	☐	☐	☐	☐
	(u) Shingles	☐	☐	☐	☐
	(v) Incontinence or other Bowel or Bladder Disease/Disorder	☐	☐	☐	☐
2	In the past 5 years have you been diagnosed with, treated for, had testing for, or consulted with a medical professional for conditions or symptoms not listed above?	☐	☐	☐	☐
3	Do you have, for your use, a handicap parking sticker or handicap license plate?	☐	☐	☐	☐
4	In the past 3 years has a medical professional referred you to a specialist for additional consultation, testing, or surgery?	☐	☐	☐	☐
5	Are you scheduled for a visit with a medical professional within the next 6 months?	☐	☐	☐	☐
6	Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?	☐	☐	☐	☐
7	Have you received inpatient or outpatient treatment at a hospital, surgical center, or rehabilitation facility in the past 12 months?	☐	☐	☐	☐
8	What is your height?	' "		' "	
9	What is your weight?	lbs		lbs	
10	Have you had an unplanned weight change in the past 12 months?	☐	☐	☐	☐

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If "Yes," to any additional health questions in Section G, please provide the following details for each "Yes" answer below.
(Attach additional signed page(s) if more space is needed.)

Applicant A

	Health Condition/Details	Month/ Year Diagnosed	Month/ Year for Last Visit	Reason for Last Visit	Month/ Year for Next Visit	Reason for Next Visit	Physician or Facility Name, Address and Phone Number
Ques # ____							
Ques # ____							
Ques # ____							
Ques # ____							
Applicant B							
Ques # ____							
Ques # ____							
Ques # ____							
Ques # ____							

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Section H MEDICAL HEALTH HISTORY

Applicant A

1 To the best of your knowledge has your biological mother, father, or sibling been diagnosed with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No

2 Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
When? ____

3 Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
When? ____

4 Have you received physical, occupational or speech therapy in the past 6 months? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
Date of last therapy? ____
Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No

5 Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No
If **"Yes,"**
Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No
If **"Yes,"** How often do you use it? ____

6 Have you used insulin in the past 6 months? ☐ Yes ☐ No
If **"Yes,"**
Units used each day? ____
Year insulin was first prescribed? ____

7 Have you ever used tobacco? ☐ Yes ☐ No
If **"Yes,"** date last used? ____

8 During the last 10 years, have you ever used unlawful drugs, or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No
If **"Yes,"**
Substance? ____
Date last used? ____

9 Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No
If **"Yes,"** date last treatment, consultation or hospitalization? ____

10 Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No

11 Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No
If **"Yes,"**
Month and year of treatment, consultation or hospitalization? ____
Month and year you last consumed alcohol? ____

Applicant B

1 To the best of your knowledge has your biological mother, father, or sibling been diagnosed with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No

2 Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
When? ____

3 Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
When? ____

4 Have you received physical, occupational or speech therapy in the past 6 months? ☐ Yes ☐ No
If **"Yes,"**
Why? ____
Date of last therapy? ____
Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No

5 Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No
If **"Yes,"**
Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No
If **"Yes,"** How often do you use it? ____

6 Have you used insulin in the past 6 months? ☐ Yes ☐ No
If **"Yes,"**
Units used each day? ____
Year insulin was first prescribed? ____

7 Have you ever used tobacco? ☐ Yes ☐ No
If **"Yes,"** date last used? ____

8 During the last 10 years, have you ever used unlawful drugs, or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No
If **"Yes,"**
Substance? ____
Date last used? ____

9 Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No
If **"Yes,"** date last treatment, consultation or hospitalization? ____

10 Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No

11 Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No
If **"Yes,"**
Month and year of treatment, consultation or hospitalization? ____
Month and year you last consumed alcohol? ____

INSTRUCTIONS: Complete Section I for MUTUALCARE SECURE SOLUTION – OR – Section J for MUTUALCARE CUSTOM SOLUTION.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section I — MUTUALCARE SECURE SOLUTION

Applicant A

☐ **MutualCare Secure Solution**

Standard MutualCare Secure Solution Benefits:

- NH, ALF and HHC Benefits are each up to 100% of the MMB
- Cash Benefit is 30% of HHC Benefit up to a maximum of $2,400
- 90-Day Elimination Period

1 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐☐ per month
($1,800-$10,000 in $1 increments)

2 Policy Limit = number of months selected (must check one) multiplied by the MMB:

☐ 24 months (2 Year)
☐ 36 months (3 Year)
☐ 48 months (4 Year)
☐ 60 months (5 Year)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If **"NO,"** signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X ______________________________
Signature of Applicant A

If you selected "NO" to the 5% Compound Lifetime Benefit, check one Inflation Option below:

☐ No Inflation Protection
☐ 3% Lifetime Benefit
☐ 4% Lifetime Benefit
☐ 3% Limited Period Benefit - 20 Year
☐ 5% Limited Period Benefit - 20 Year

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Applicant B (If selecting Shared Care Benefit, benefits must be identical to Applicant A)

☐ **MutualCare Secure Solution**

1 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐☐ per month
($1,800-$10,000 in $1 increments)

2 Policy Limit = number of months selected (must check one) multiplied by the MMB:

☐ 24 months (2 Year)
☐ 36 months (3 Year)
☐ 48 months (4 Year)
☐ 60 months (5 Year)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If **"NO,"** signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X ______________________________
Signature of Applicant B

If you selected "NO" to the 5% Compound Lifetime Benefit, check one Inflation Option below:

☐ No Inflation Protection
☐ 3% Lifetime Benefit
☐ 4% Lifetime Benefit
☐ 3% Limited Period Benefit - 20 Year
☐ 5% Limited Period Benefit - 20 Year

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Complete Section I Optional Benefits for MUTUALCARE SECURE SOLUTION to change or add benefits.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section I (continued) OPTIONAL BENEFITS FOR MUTUALCARE SECURE SOLUTION

Applicant A	Applicant B
5 ALF Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50%	**5 ALF Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50%
6 HHC Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.	**6 HHC Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.
7 Calendar Day Elimination Period: **(90-Day Elimination Period is default if no option selected)** ☐ 180 Day ☐ 365 Day	**7 Calendar Day Elimination Period:** **(90-Day Elimination Period is default if no option selected)** ☐ 180 Day ☐ 365 Day
8 ☐ **Waiver of Elimination Period for HHC Benefit**	**8** ☐ **Waiver of Elimination Period for HHC Benefit**
9 ☐ **Shared Care Benefit** Only available when both Partners apply at the same time and both policies are issued with identical benefits.	**9**
10 ☐ **Security Benefit** Not available for issue ages 70 and older, with Shared Care Benefit or if Partner is applying for this coverage. ____________________ Partner's Name	**10**
11 Return of Premium at Death Benefit: ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)	**11 Return of Premium at Death Benefit:** ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)

If you completed Section I for MUTUALCARE SECURE SOLUTION – SKIP Section J and continue to Section K.

Complete Section J for MUTUALCARE CUSTOM SOLUTION if Section I for MUTUALCARE SECURE SOLUTION was not selected.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section J — MUTUALCARE CUSTOM SOLUTION

Applicant A

☐ **MutualCare Custom Solution**

Standard MutualCare Custom Solution Benefits:

- NH, ALF and HHC Benefits are each up to 100% of the MMB
- Cash Benefit is 40% of HHC Benefit up to a maximum of $2,400
- 90-Day Elimination Period

1 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐0 per month

($1,800-$10,000 in $50 increments)

2 Policy Limit (must enter):

$ ☐☐☐,☐00

($50,000-$500,000 in $500 increments)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If **"NO,"** signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X ______________________________
Signature of Applicant A

If you selected "NO" to the 5% Compound Lifetime Benefit, check either No Inflation Option, OR select an alternate Inflation Option below:

☐ No Inflation Protection

OR

Select one of the following inflation percentage options:

☐ 1%	☐ 1.25%	☐ 1.50%	☐ 1.75%
☐ 2%	☐ 2.25%	☐ 2.50%	☐ 2.75%
☐ 3%	☐ 3.25%	☐ 3.50%	☐ 3.75%
☐ 4%	☐ 4.25%	☐ 4.50%	☐ 4.75%
☐ 5%			

(Compound Lifetime with Buy-Up is default if no optional Limited Period Benefit selected below.)

☐ 10 Year with Buy-Up
☐ 15 Year with Buy-Up
☐ 20 Year with Buy-Up

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Applicant B (If selecting Shared Care Benefit, benefits must be identical to Applicant A)

☐ **MutualCare Custom Solution**

1 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐0 per month

($1,800-$10,000 in $50 increments)

2 Policy Limit (must enter):

$ ☐☐☐,☐00

($50,000-$500,000 in $500 increments)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If **"NO,"** signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X ______________________________
Signature of Applicant B

If you selected "NO" to the 5% Compound Lifetime Benefit, check either No Inflation Option, OR select an alternate Inflation Option below:

☐ No Inflation Protection

OR

Select one of the following inflation percentage options:

☐ 1%	☐ 1.25%	☐ 1.50%	☐ 1.75%
☐ 2%	☐ 2.25%	☐ 2.50%	☐ 2.75%
☐ 3%	☐ 3.25%	☐ 3.50%	☐ 3.75%
☐ 4%	☐ 4.25%	☐ 4.50%	☐ 4.75%
☐ 5%			

(Compound Lifetime with Buy-Up is default if no optional Limited Period Benefit selected below.)

☐ 10 Year with Buy-Up
☐ 15 Year with Buy-Up
☐ 20 Year with Buy-Up

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Complete Section J Optional Benefits for MUTUALCARE CUSTOM SOLUTION to change or add benefits.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section J (continued) OPTIONAL BENEFITS FOR MUTUALCARE CUSTOM SOLUTION

Applicant A

5 ALF Benefit Reduced from 100% of MMB to:

- ☐ 75%
- ☐ 50%

6 HHC Benefit Reduced from 100% of MMB to:

- ☐ 75%
- ☐ 50%

Reducing the **HHC Benefit** will reduce the **Cash Benefit**.

7 Calendar Day Elimination Period:
(90-Day Elimination Period is default if no option selected)

- ☐ 0 Day
- ☐ 30 Day
- ☐ 60 Day
- ☐ 180 Day
- ☐ 365 Day

8 ☐ **Waiver of Elimination Period for HHC Benefit**

9 ☐ **Professional HHC Benefit**

10 Partner Benefits:

The **Joint Waiver of Premium, Survivorship Benefit** and **Shared Care Benefit** are only available when both Partners apply at the same time and both policies are issued.

- ☐ **Joint Waiver of Premium**
- ☐ **Survivorship Benefit**
- ☐ **Shared Care Benefit**

The **Shared Care Benefit** is only available when both policies are issued with identical benefits.

11 ☐ **Security Benefit**
Not available for issue ages 70 and older, with other Partner Benefits or if Partner is applying for this coverage.

____
Partner's Name

12 Return of Premium at Death Benefit:

☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)

OR

☐ Return of Premium (Minus Claims Paid) If Death Occurs Before Age 65

OR

☐ Return of Premium at Death (Minus Claims Paid)

Applicant B

5 ALF Benefit Reduced from 100% of MMB to:

- ☐ 75%
- ☐ 50%

6 HHC Benefit Reduced from 100% of MMB to:

- ☐ 75%
- ☐ 50%

Reducing the **HHC Benefit** will reduce the **Cash Benefit**.

7 Calendar Day Elimination Period:
(90-Day Elimination Period is default if no option selected)

- ☐ 0 Day
- ☐ 30 Day
- ☐ 60 Day
- ☐ 180 Day
- ☐ 365 Day

8 ☐ **Waiver of Elimination Period for HHC Benefit**

9 ☐ **Professional HHC Benefit**

10

11

12 Return of Premium at Death Benefit:

☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)

OR

☐ Return of Premium (Minus Claims Paid) If Death Occurs Before Age 65

OR

☐ Return of Premium at Death (Minus Claims Paid)

Continue to Section K.

Section K PREMIUM INFORMATION

Applicant A

1 Premium Option:

☑ Lifetime

2 Select Effective Date:

☐ Date of Application (Initial Premium Required)

☐ Date Policy is Issued

☐ For Replacements Only, Requested Effective Date of Coverage ______________ (up to 60 days from application date)

3 Initial Premium Payment:

Initial Premium Collected: $______________ Two Months Minimum

☐ Check

☐ Automatic Bank Account Withdrawal
Note: Complete and Sign Payment Authorization below.

4 Recurring Premium Payment:
(Annual Direct Bill Mode is default if no option selected)

Modal Premium: $ ______________

☐ Annual Direct Bill

☐ Semiannual Direct Bill

☐ Quarterly Direct Bill

☐ Monthly Automatic Bank Account Withdrawal
Note: Complete and Sign Payment Authorization below.

Applicant B

1 Premium Option:

☑ Lifetime

2 Select Effective Date:

☐ Date of Application (Initial Premium Required)

☐ Date Policy is Issued

☐ For Replacements Only, Requested Effective Date of Coverage ______________ (up to 60 days from application date)

3 Initial Premium Payment:

Initial Premium Collected: $______________ Two Months Minimum

☐ Check

☐ Automatic Bank Account Withdrawal
Note: Complete and Sign Payment Authorization below.

4 Recurring Premium Payment:
(Annual Direct Bill Mode is default if no option selected)

Modal Premium: $ ______________

☐ Annual Direct Bill

☐ Semiannual Direct Bill

☐ Quarterly Direct Bill

☐ Monthly Automatic Bank Account Withdrawal
Note: Complete and Sign Payment Authorization below.

Payment Authorization

(Complete and Sign if Initial and/or Recurring Monthly Automatic Bank Account Withdrawal Selected.)

Applicant A

Specify the date Recurring premiums will be withdrawn (1st through the 28th of the month): __________

Note: Initial Premium will be withdrawn within 3 days of receipt of application.

Bank Name: ______________

Complete information below or attach a voided check.

Bank Routing Number: ______________

Bank Account Number: ______________ (Do not use Debit/Credit Card numbers)

Applicant B

Specify the date Recurring premiums will be withdrawn (1st through the 28th of the month): __________

Note: Initial Premium will be withdrawn within 3 days of receipt of application.

Bank Name: ______________

Complete information below or attach a voided check.

Bank Routing Number: ______________

Bank Account Number: ______________ (Do not use Debit/Credit Card numbers)

When choosing automatic bank account withdrawal, **MONEY MAY BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON RECEIPT OF YOUR APPLICATION, BUT IN NO EVENT LATER THAN AT POLICY ISSUE**. The first withdrawal date or charge date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the withdrawal or charge may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums as indicated above and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

X ______________ ______
Authorized Signature as Shown on Account Date

X ______________ ______
Authorized Signature as Shown on Account Date

Section L — PROTECTION AGAINST UNINTENTIONAL LAPSE

Must check the applicable box. Complete the requested information if you designate an additional person. You may want to consider designating someone other than your Partner. The designee cannot be the producer unless related to the applicant.

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.

Applicant A

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

OR

☐ I designate the following person to receive notice of lapse or termination of the policy due to nonpayment of premium:

Name (Print full name of other person to receive notice of lapse or termination)

Street Address, Apartment Number

City, State, ZIP Code

Applicant B

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

OR

☐ I designate the following person to receive notice of lapse or termination of the policy due to nonpayment of premium:

(If Different than Applicant A)

Name (Print full name of other person to receive notice of lapse or termination)

Street Address, Apartment Number

City, State, ZIP Code

Section M AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha Insurance Company may require: an Attending Physician's Statement, medical records, an underwriting assessment, a medical examination, or other information for underwriting purposes.
3. Applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement), and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force.
4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions under any temporary insurance agreement or conditional receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the long-term care coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha Insurance Company (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. A completed and signed application will become part of each applicant's policy.
6. Applicant acknowledges that no Producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
7. Applicant acknowledges receipt of an Outline of Coverage, Shopper's Guide to Long-Term Care Insurance, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Potential Rate Increase Disclosure Form and, if applicable, *Guide to Health Insurance for People with Medicare*.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 this Agreements and Acknowledgements Section, including the Fraud Warning and I approve all my answers as recorded in this application.

Signed at ______________________ ________
City State

X ______________________ ________
Signature of Applicant A Date

Signed at ______________________ ________
City State

X ______________________ ________
Signature of Applicant B Date

I/We, the Producer(s) certify that each question was asked exactly as written and I/we have recorded the answers provided by the Applicant(s) completely and accurately. I/We also agree that my/our answers in this application are true and complete.

☐ **Yes** ☐ **No** (If "No," please explain) ______________________

X ______________________
Signature of Licensed Producer

X ______________________
Signature of Other Licensed Producer, if applicable

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Appendix 1 — AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my “Personal Information,” which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB, Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me to release Personal Information about me to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my Personal Information to MIB, Inc. I understand that my Personal Information received by MIB, Inc. 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 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 be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. 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. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Applicant acknowledges and agrees that if there is more than one Applicant on this application, all information provided may be reviewed or shared with the other Applicant. A completed and signed application will become part of each applicant’s policy.

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

____

Printed Name of Applicant A	Birth Date	Birth State	Printed Name of Applicant B	Birth Date	Birth State
✍ X Signature of Applicant A		Date	✍ X Signature of Applicant B		Date

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

Appendix 2 PRODUCER STATEMENT

		Yes	No
1.	I/We certify that each question was asked exactly as written and that I/we recorded the answers completely and accurately..........	☐	☐
2.	I/We certify that the application was completed in the physical presence of the Applicant(s) .... (If "No," explain) ____________	☐	☐
3.	This coverage is written on myself (the Producer) and/or my Partner.......... Partner's name ____________	☐	☐

		Applicant A	Applicant B
4.	Please indicate the Underwriting Risk classification quoted.......... **Your quote will be noted, however, Underwriting will determine the final risk classification. We suggest quoting Select unless our Underwriting Guide indicates the health condition(s) warrants a substandard rating. Class II cases should be discussed with an underwriter prior to application submission.**	☐ Preferred ☐ Select ☐ Class I ☐ Class II	☐ Preferred ☐ Select ☐ Class I ☐ Class II
5.	To the best of my knowledge, replacement of other insurance (check box) involved in this transaction .... **If replacement is involved, I/we shall comply with all state and/or company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.**	☐ is ☐ is not	☐ is ☐ is not

By signing below, I understand I am required to have valid LTCi training completed at time of application. I further understand that if the appropriate LTCi training required by the state in which this application is signed is not valid, this application will not be processed and a new application will be required in order to continue the underwriting process.

X ____________________ ____________
Signature of Producer (Agent of Record) Date

X ____________________ ____________
Signature of Other Producer, if applicable Date

Producer Information (please print clearly)

For Mutual of Omaha Career Producers Only: **01** ____________
Manager Stamp

For Brokerage Only: Commission Code ☐☐ 951300 (**Examples:** 8 8, A 2, etc.)
(Commission Code available from your marketing organization)

Agent of Record:

Producer's Name ____________ Last 4 of Social Security # ________ Comm. % Share ________
Identification # ____________ Phone ____________ Email ____________

If applicable, for Commission Split:

Other Producer's Name ____________ Last 4 of Social Security # ________ Comm. % Share ________
Identification # ____________ Phone ____________ Email ____________

Other Producer's Name ____________ Last 4 of Social Security # ________ Comm. % Share ________
Identification # ____________ Phone ____________ Email ____________

Whom should we contact with questions regarding this application if different than Producer listed above:
(please print clearly)

Name ____________

Name of Office/Corporation ____________

Phone Number ____________

Email Address

____

SUBMIT TO LTC SERVICE OFFICE

Appendix 3 **CONDITIONAL RECEIPT**

CONDITIONS

This receipt is given and accepted with the understanding that the insurance applied for by each applicant will become effective on the date of the completed application (unless a later date is selected by the applicant, in which case coverage will become effective on the date selected by the applicant) if all of the following conditions have been fully satisfied:

1. The insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company,
2. Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement),
3. The insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force, and the policy is issued, and
4. The minimum premium of at least two month's is received on the date of the application via check or authorized Automatic Bank Account Withdrawal and is honored on its first presentation for payment.

Applicant A	**Applicant B**
Payment or payment authorization has been received for **Applicant A** for the amount of $ ____________________ as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.	Payment or payment authorization has been received for **Applicant B** for the amount of $ ____________________ as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Total Premium
$

Payment Method: ☐ Check ☐ Automatic Bank Account Withdrawal

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

SIGNATURES

Mutual of Omaha Insurance Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, Mutual of Omaha Insurance Company will return monies received with the application if (a) the coverage, other than applied for, is offered but not accepted, or (b) if the coverage is declined. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application for coverage.

This is not a temporary insurance agreement and does not create any temporary or interim insurance. I/We understand that the Producer has no authority to change the terms of this Receipt.

X ____________________ ________
Signature of Applicant A Date

X ____________________ ________
Signature of Applicant B Date

I/We agree that I/we am/are not authorized to change or waive the terms of this Receipt and represent that I/we have not attempted to do so. I/We have read and explained the terms of this Receipt and have left a copy with the Applicant(s).

X ____________________ ________
Signature of Licensed Producer Date

X ____________________ ________
Signature of Other Licensed Producer, if applicable Date

ICC13-LTC13CR

Long-Term Care Insurance

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

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 thirty (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 Producer

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 that 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 or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) 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 producer 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.

X ______________________________
Signature of Producer

____
Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X	
Signature of Applicant A	Date
X	
Signature of Applicant B	Date

ICC13-M28368

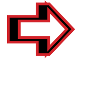
MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

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 (✓)** **Applicant A**	 **Applicant B**
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. Change from non-partnership qualified to partnership qualified		
8. At least a 20% increase in daily benefit amount		
9. Increase in benefit period; or		
10. Decrease in Elimination Period		

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



X

Signature of Producer

Printed Name and Address of Producer

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, South Dakota** and **Wisconsin** only.

M21224_1208

SUBMIT TO LTC SERVICE OFFICE

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

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: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

✍ X ______________________	________	✍ X ______________________	________
Signature of Applicant A	Date	Signature of Applicant B	Date

M28704

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s) if applicable.

Required Forms to be Left with Applicant(s)			
Conditional Receipt *(applicable if initial payment provided with app)*	Replacement Notice *(if applicable)*	MIB Inc. Pre-Notice	Things You Should Know Before You Buy Long-Term Care Insurance
Long-Term Care Insurance Potential Rate Increase Disclosure Form	Partnership Notices	Authorization for Release of Information to My Insurance Agent and/or Agency *(if applicable)*	Outline of Coverage

Not Contained within this Application Package:

Required Forms to be Left with Applicant(s) that are Not Included within this Package	
LTC Shopper's Guide *(Not included within this package. Please provide in addition.)*	Guide to Medicare for People Age 65 and Older *(Not included within this package. If applicable, please provide in addition.)*

CONDITIONAL RECEIPT

CONDITIONS

This receipt is given and accepted with the understanding that the insurance applied for by each applicant will become effective on the date of the completed application (unless a later date is selected by the applicant, in which case coverage will become effective on the date selected by the applicant) if all of the following conditions have been fully satisfied:

1. The insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company,
2. Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement),
3. The insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force, and the policy is issued, and
4. The minimum premium of at least two month's is received on the date of the application via check or authorized Automatic Bank Account Withdrawal and is honored on its first presentation for payment.

Applicant A	Applicant B
Payment or payment authorization has been received for **Applicant A** for the amount of $ ____________________ as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.	Payment or payment authorization has been received for **Applicant B** for the amount of $ ____________________ as the initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Total Premium
$

Payment Method: ☐ Check ☐ Automatic Bank Account Withdrawal

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

SIGNATURES

Mutual of Omaha Insurance Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, Mutual of Omaha Insurance Company will return monies received with the application if (a) the coverage, other than applied for, is offered but not accepted, or (b) if the coverage is declined. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application for coverage.

This is not a temporary insurance agreement and does not create any temporary or interim insurance. I/We understand that the Producer has no authority to change the terms of this Receipt.

X ______________________________ Signature of Applicant A ______ Date

X ______________________________ Signature of Applicant B ______ Date

I/We agree that I/we am/are not authorized to change or waive the terms of this Receipt and represent that I/we have not attempted to do so. I/We have read and explained the terms of this Receipt and have left a copy with the Applicant(s).

X ______________________________ Signature of Licensed Producer ______ Date

X ______________________________ Signature of Other Licensed Producer, if applicable ______ Date

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

Long-Term Care Insurance

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

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 thirty (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 Producer

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 that 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 or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) 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 producer 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.

X ______________________________
Signature of Producer

____
Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X ______________________________ ________
Signature of Applicant A | Date

X ______________________________ ________
Signature of Applicant B | Date

ICC13-M28368

Leave this page with Applicant(s)

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of 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 is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

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 producer gives you a copy of a book called the National Association of Insurance Commissioners' "A 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. For more information about the Senior health insurance counseling program in your state, contact the state agency listed in the Directories in the above mentioned Shopper's Guide to Long-Term Care Insurance.

FACILITIES

Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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: Applicant A $ ___________ Applicant B $ ___________
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.)

***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 greater of the total amount of premiums you've paid since your policy was first issued or the maximum monthly benefit. If you have already received benefits under the policy, so that the remaining lifetime 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 at least $10,000 of benefits remaining under your policy).

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

ICC13-M28370

LEAVE THIS PAGE WITH APPLICANT(S)

PARTNERSHIP POLICY STATUS DISCLOSURE NOTICE

Important Notice Regarding Your Policy's Long-Term Care Insurance Partnership Plan Status

(Please keep this Notice with Your Policy or Certificate)

The Wisconsin Long-Term Care Insurance Partnership Program (Wisconsin Partnership Program) is a partnership between the State of Wisconsin and private insurers of long-term care insurance policies/certificates. The Wisconsin Partnership Program became effective on January 1, 2009. This Notice explains the Medicaid asset protection that you may receive being insured under a Partnership Policy/Certificate.

Notice of Partnership Plan Policy Status. Your long-term care insurance policy/certificate is intended to qualify as a Qualifying Partnership Policy/Certificate under the Wisconsin Long-Term Care Insurance Partnership Program as of your policy's/certificate's effective date.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

Medicaid Asset Protection Provided by the State Medicaid Program. Long-term care insurance is one tool that helps individuals prepare for future long-term care needs. **The purchase of a Qualifying Partnership Policy/Certificate does not automatically qualify you for Medicaid.**

In particular, such policies/certificates may permit individuals to protect assets from spend-down requirements under Wisconsin's Medicaid program if assistance under this program is ever needed and you otherwise qualify for Medicaid.

Specifically, the asset eligibility and recovery provisions of the Wisconsin Medicaid program are applied by disregarding the amount of assets equal to the amount of insurance benefits you have received from your Qualifying Partnership Policy/Certificate. The disregarded assets are also exempt from estate recovery. For example, if you receive $200,000 of insurance benefits from your Qualifying Partnership Policy/Certificate, you generally would be able to retain $200,000 of assets above and beyond the amount of assets normally permitted for Medicaid eligibility.

Other Medicaid eligibility requirements apart from permissible assets shall be met, including special rules that may apply if the equity in your home exceeds $750,000. In addition, you shall meet the Medicaid program's income requirements and may be required to contribute some of your income to the costs of your care once you become eligible for Medicaid. Medicaid eligibility requirements may vary by county and may change over time. Medicaid eligibility requirements may also be different from state to state.

Additional Consumer Protections. In addition to providing Medicaid asset protection, your Partnership Policy/Certificate has other important features. Under the rules governing Wisconsin's Long-Term Care Insurance Partnership Program, your Qualifying Partnership Policy/Certificate shall be a tax-qualified long-term care insurance contract under Federal tax law, and as such the insurance benefits you receive from the policy generally will not be subject to income tax. (Please note that a policy or certificate can be a qualified long-term care insurance contract under Federal and State income tax law, with the same income tax treatment, even if it is not a Qualifying Partnership Policy/Certificate.) In addition, if you were under age 76 when you purchased your Qualifying Partnership Policy/Certificate, it shall provide inflation protection to help protect against potential future increases in the cost of long-term care. (For older purchasers, only an offer of inflation protection is required.)

What Could Disqualify Your Policy as a Partnership Policy/Certificate. If you make any changes to your policy or certificate, such changes could affect whether your policy/certificate continues to be a Qualifying Partnership Policy/Certificate. Before you make any changes, you should consult with the Mutual of Omaha Insurance Company to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy as a Qualifying Partnership Policy/Certificate, you would not receive Medicaid asset protection in that state. However, the coverage contained in your policy would not be affected. Also, changes in Federal or State law could modify, reduce or eliminate the Medicaid asset protection available with respect to your Qualifying Partnership Policy/Certificate after you have purchased the policy.

Additional information. If you would like further information about the Medicaid asset protection provided by your Qualifying Partnership Policy/Certificate or the Wisconsin's Long-Term Care Insurance Partnership Program, please contact State of Wisconsin Member Services at 1-800-362-3002.

MPARTNOTICE-WI

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

Partnership Program Notice

Important Consumer Information Regarding the Wisconsin Long-Term Care Insurance Partnership Program

Some long-term care insurance policies/certificates sold in Wisconsin may qualify for the Wisconsin Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies/certificates that qualify as Partnership Policies/Certificates may protect the policyholder's/certificateholder's assets through a feature known as "Asset Disregard" under Wisconsin's Medicaid program.

Asset Disregard means that amount of the policyholder's/certificateholder's assets equal to the amount of long-term care insurance benefits received under a Qualifying Partnership Policy/Certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a Qualifying Partnership Policy/Certificate without affecting the person's eligibility for Medicaid. The disregarded assets are also exempt from estate recovery. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $750,000. Asset Disregard is available under a Qualifying Partnership Policy/Certificate. Therefore, you should consider if Asset Disregard is important to you, and whether a Qualifying Partnership Policy meets your needs. The purchase of a Qualifying Partnership Policy does not automatically qualify you for Medicaid.

What are the Requirements for a Partnership Policy/Certificate? In order for a policy/certificate to qualify as a Qualifying Partnership Policy/Certificate, it shall, among other requirements:

- be issued to an individual after January 1, 2009;
- be issued to an individual who was a Wisconsin resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under § 7702(B)(b) of the Internal Revenue Code of 1986, as amended;
- meet certain consumer protection standards; and
- meet the following inflation requirements:

  For persons ages 60 or younger - provides compound annual inflation protection of at least 3%

  For persons ages 61 to 75 - provide annual inflation protection of at least 3% not compounded

  For persons ages 76 and older - there are no requirements for purchasing inflation protection

If you apply and are approved for long-term care insurance coverage, Mutual of Omaha Insurance Company will provide you with written documentation as to whether or not your policy/certificate is a Qualifying Partnership Policy/Certificate.

You should also be aware that insurers are required to provide personally identifying information, including your name, to the federal government to be entered into a federal data base to which state Medicaid departments will have access.

What Could Disqualify a Policy/Certificate as a Partnership Policy. Certain types of changes to a Qualifying Partnership Policy/Certificate could affect whether or not such policy/certificate continues to be a Qualifying Partnership Policy/Certificate. If you purchase a Qualifying Partnership Policy/Certificate and later decide to make a change, you should first consult with Mutual of Omaha Insurance Company to determine the effect of the proposed changes. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy/certificate as a Qualifying Partnership Policy/Certificate, you would not receive treatment of you policy/certificate under the Medicaid program of that state. However, the coverage under your policy will not be affected. The information contained in this disclosure is based upon current Wisconsin and Federal laws. These laws may be subject to change. Any change in law could modify, reduce or eliminate the treatment of your policy/certificate under Wisconsin's Medicaid program..

Additional Information. If you have questions regarding long-term care insurance policies/certificates please contact Mutual of Omaha Insurance Company. If you have questions regarding current laws governing Wisconsin Medicaid eligibility, you should contact the State of Wisconsin Member Services at 1-800-362-3002.

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

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: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

✍ X ______________________ Signature of Applicant A ______ Date

✍ X ______________________ Signature of Applicant B ______ Date