



Critical Illness – TEXAS

Application Submission Checklist

Application

- 1 Must be taken during an in-person interview (cannot mail or complete via phone).
- 2 Answer all questions in full.
- 3 Be sure to leave all applicable forms with the proposed insured.
- 4 Sign and Date in all places indicated.
- 5 See reverse side of this page for additional detailed information.

Privacy Authorizations

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

Collect Premium Amount

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

Attach Copy of Quote (if available)

For face amounts of \$100,000 or more

Initiate the Client Profile Process with the proposed insured – Call 1-800-775-3000

Schedule Paramed Exam

APPS 1-800-635-1677

PORTAMEDIC 1-800-765-1010

Indicate underwriting requirements initiated or completed

Client Profile Interview

Physical Data

Oral Fluid Test

Blood Profile

Urinalysis

Financial Institution Consumer Disclosure

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

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

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

Any Additional Information or Comments _____

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

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

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

Part 1: APPLICATION

- Notify the applicant that a telephone interview may be conducted to obtain additional information and/or to verify application information.
- Indicate types of coverage(s) at the top of page one.

Section A: General Questions

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.

Section B: Underwriting Information

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

Section C: Plan Information

- The total premium amount must be listed within each section. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual BSP), and amount of renewal premium. Collect two months for Bank Service Plan (BSP).

Section D: Other Coverage Information

- All details of other coverages (inforce or being applied for) must be listed.

Section E: Agreements

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

Part 2: ADMINISTRATIVE FORMS

Privacy Authorizations

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

Receipt and/or Temporary Health and Accident Insurance Agreement

- Detach and leave with proposed insured.

Agent/Producer Statement

- This is necessary information for the underwriting process.
- Until further notice only agency commissions can be split.

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company [BSP] – complete if applicable

- Payments will be taken monthly, on the 1st or the 15th of the month. Checking account information will be taken from the accompanying premium check (2 months premium must be collected for BSP).

Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice

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

HIV Consent Form – if required

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

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

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

Addition to Existing Coverage

(Policy Number)

Application for policy form(s)
 CI
 CI1

Section A General Questions

1 Proposed Insured's Name _____
First Middle Last

2 Home Phone Number (_____) _____ State of Birth _____
Area Code

3 Legal Residence Address _____
Number Street City State ZIP Code

E-mail Address _____

4 Mailing Address for Premium Notices _____
Number Street City State ZIP Code

5 Is each person proposed for insurance a citizen of the United States? Yes No
If "No," do all non-citizens have an alien registration receipt "Permanent Visa"? Yes No
If "Yes," Name _____ Permanent Visa Number _____ Date of arrival in United States _____
If "Yes," Name _____ Permanent Visa Number _____ Date of arrival in United States _____

6 Occupation _____ Duties _____
Your Income _____ Spouse's Income _____ Household Income _____ Mortgage Balance _____
Are you currently engaged in your occupation on an active full-time basis (30 or more hours per week)? Yes No
(If "No," explain including date of last full-time work.)

Name of your firm or employer and address _____

Work Phone Number (_____) _____
Area Code

Spouse's Occupation _____ Spouse's Duties _____

Is your spouse currently engaged in his/her occupation on an active full-time basis (30 or more hours per week)?
 Yes No (If "No," explain including date of last full-time work.)

Name of spouse's firm or employer and address _____

7 Please complete for all persons proposed for insurance.

Name (First/Middle/Last)	Social Security Number	Relationship to Proposed Insured	Birth Date Mo./Day/Yr.	Age	Sex	Ht.	Wt.
		Self					
		Spouse					

Section B Underwriting Information

- 1 Has any person proposed for insurance ever received medical care for or had the following conditions: (Check all that apply. Provide explanation for all checked boxes in number 9.)
- | | | |
|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eye or Ear Disorder | <input type="checkbox"/> Psychological, Emotional or Nervous condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Paralysis or Numbness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Disorder |
| <input type="checkbox"/> Back Disorder | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Respiratory Disorder |
| <input type="checkbox"/> Breast Disease or Disorder | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Stroke or TIA (Transient Ischemic Attack) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Major Organ Transplant | <input type="checkbox"/> Tumor, Polyp or Growth |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> None of These |
| <input type="checkbox"/> Digestive Disorder | | |

Section B

Underwriting Information (Continued)

2 Has any person proposed for insurance ever 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)?..... Yes No
(If "Yes," provide explanation in number 9.)

3 During the past 10 years, other than shown in B1 and B2, has any person proposed for insurance: (Check all that apply. Provide explanation for all checked boxes in number 9.)

- Been diagnosed or treated by a health care provider (including a Medical Doctor, Chiropractor, Psychologist, Podiatrist or other health care professional)?
- Had or been advised to seek treatment for any illness, injury or disorder?
- Had surgery?
- Been hospitalized?
- Had a medical examination, diagnostic or medical evaluation or received medical care?
- None of These**

4 Has any proposed insureds' natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than skin cancer)?..... Yes No

Person Proposed For Insurance	Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

5 (a) Within the past six months, has any person proposed for insurance taken any prescription medication?.... Yes No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Medication Name (Copy From Pharmacy Label)	Dosage/Frequency	Date	Prescribing Physician	Phone Number	Reason

(b) Within the past six months, has any person proposed for insurance taken any over-the-counter drugs on a regular basis?..... Yes No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Medication Name	Dosage/Frequency	Reason

6 During the past 12 months, has any person proposed for insurance used:
(a) any form of tobacco?..... Yes No
(b) any form of nicotine replacement therapy (for example – nicotine gum, patch or spray)? Yes No
If you answered "Yes" in 6 (a) or (b), please provide details below.

Person Proposed For Insurance	What Form	Number Per Day	Stopped On

7 During the past 10 years, has any person proposed for insurance used unlawful drugs in any form (including cocaine and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?..... Yes No
(If "Yes," provide explanation in number 9.)

8 Is any person proposed for insurance pregnant? Yes No
If "Yes," history of complications? Yes No
(If "Yes," provide explanation in number 9.)

9 Complete this section to provide additional information on questions 1, 2, 3, 7 and 8 in Section B. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Condition(s)	Provider, City/State	Phone Number

Section C Plan Information (Availability of plan and riders is subject to change.)

Complete for Proposed Insured		Complete for Spouse (if a Proposed Insured)	
	Yes	No	
Base Policy Benefit Amount \$ _____			Base Policy Benefit Amount \$ _____
Accidental Death & Dismemberment Benefit Rider <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment Benefit Rider <input type="checkbox"/>
AD&D Benefit Rider Amount \$ _____			AD&D Benefit Rider Amount \$ _____
Disability Benefit Rider <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disability Benefit Rider <input type="checkbox"/>
Hospital Confinement Benefit Rider <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospital Confinement Benefit Rider <input type="checkbox"/>
Premium Collected \$ _____			Premium Collected \$ _____
Renewal Premium \$ _____			Renewal Premium \$ _____

Billing Mode BSP Annual Semi-Annual Quarterly PRD

Section D Other Coverage Information

- Does any person proposed for insurance currently have, or is such person applying for, Critical Illness (lump-sum diagnostic benefits) coverage with any company?..... Yes No
If "Yes," give details including the name(s) of such person(s), name of the company, policy/plan number and termination date. _____
- Is any person proposed for insurance purchasing this insurance to replace any existing insurance? Yes No
(a) If "Yes," give details, including the name(s) of such person(s), name of the company, policy/plan number and termination date. _____
(b) If "Yes," has each person proposed for insurance received a copy of the Notice of Replacement (if required in your state)?..... Yes No
- Is any person proposed for insurance eligible for, or receiving benefits from, Medicare or Medicaid? Yes No
If "Yes," please provide name(s) of individual(s) and details. _____
- Has each person proposed for insurance received the appropriate Outline/Summary of Coverage? Yes No
- Complete only for Association or Franchise Coverage**
I/We belong to the _____ Date joined _____
(Full Name of Organization) (Mo.) (Yr.)
- Full name of your beneficiary _____
Relationship _____
- If the spouse is a proposed insured, the full name of spouse's beneficiary _____
Relationship _____

Section E

Agreement & Fraud Warning

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

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

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, (a) the person proposed for insurance must complete all required examinations and tests (medical, paramedical, laboratory), and (b) Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician’s Statement) that it requires, and (c) the application must be approved for issue by Mutual of Omaha’s Underwriting Department. If all of these requirements are met, the underwriting standards of Mutual of Omaha will not apply to changes in health after the application date. **If I am not eligible for the insurance applied for, I agree that no policy of any kind will be in effect unless a substitute policy is issued and accepted by me upon delivery.**

I have received the Notice of Information Practices and the MIB Group, Inc. Pre-Notice.

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

Fraud Warning – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I/We have: (a) read the Agreement and Fraud Warning Section and the Receipt; and (b) read and approved the answers as recorded on this application.

Signed at _____ Date _____
(City) (State)

Signature of Proposed Insured

Signature of Spouse (If Proposed for Insurance)

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

(If “No,” please explain.) _____

X _____
Producer’s Signature

X _____
Producer’s Signature

(Date) Mo./Day/Yr.

(Date) Mo./Day/Yr.

Office Name

Office Name

Office Address

Office Address

Meanings of Terms

“Medical Persons and Entities” means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

“Psychotherapy Notes” means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

“Specified Companies” means:

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

Authorization to Disclose

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

Purposes

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

Potential For Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

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

Expiration and Revocation

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

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

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

Copy

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

Names and Signatures

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

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

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Meanings of Terms

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

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

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

Authorization to Receive and Disclose

To the MIB:

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

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

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

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

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

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

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

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

Signature of Proposed Insured

Date

Signature of Spouse (If Proposed Insured)

Date

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

Date

Appendix 3

Producer Statement

- 1 Do you have any reason to believe any policy applied for has replaced or will replace any existing insurance? (If "Yes," fulfill all state requirements.) Yes No
- 2 Has a medical examination of the person(s) proposed for insurance been scheduled? Yes No
If "Yes," when? _____ By _____
- 3 If benefit amounts \$100,000 or more, has the client profile interview(s) been completed? Yes No
If "No," the client profile interview(s) has/have been scheduled for _____ and _____
Date Time (Please circle – Eastern, Central, Mountain or Pacific)
- 4 Did you give the Notice of Information Practices and the MIB Group, Inc. Pre-Notice to the Proposed Insured(s)? Yes No

Date _____ Mo./Day/Yr. _____ Producer's Signature _____ Producer's Signature _____

Producer Information:

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

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

Appendix 4

Authorization to Withdraw Funds By Mutual of Omaha Insurance Company

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

- (1) _____ (3) _____
Form Proposed Insured Form Proposed Insured
- (2) _____ (4) _____
Form Proposed Insured Form Proposed Insured

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

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

III Specify the date premiums will be withdrawn: 1st of the Month or 15th of the Month

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

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

Date _____ X _____ X _____
Mo./Day/Yr. Authorized Signature as Shown on Account Joint Account or Other Authorized Signature

Appendix 5**Mutual of Omaha Insurance Company
Notice of Information Practices**

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Appendix 6**Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice**

The information regarding your insurability will be treated as confidential.

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

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

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

Appendix 7**Mutual of Omaha Insurance Company
Investigative Consumer Reports Notice**

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

Remove Notices and Give to Proposed Insured

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

All checks for premiums must be made payable to Mutual of Omaha Insurance Company. Do not make checks payable to the producer or leave the payee blank.

Received from _____ the sum of \$ _____ paid as the full initial premium with the attached _____ insurance application to Mutual of Omaha Insurance Company.

Notice to Proposed Insured(s): Eligibility for the insurance applied for, or for any substitute policy issued from this application, is subject to the following conditions:

- 1 Written application.
- 2 Payment of the full initial premium.
- 3 Completion by each Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
- 4 Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
- 5 Satisfying Mutual of Omaha Insurance Company underwriting standards.

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

Should Mutual of Omaha Insurance Company decline to issue the insurance applied for, I hereby agree to return the above sum to the Proposed Insured(s).

Date _____
Mo./Day/Yr.

X _____
Producer's Signature

Notice and Consent for HIV-Related Testing



Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

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

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The result may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.



Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

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

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result _____

Address _____

In the event that the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test result as described above. I have read the information on this form about what a test result means.

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

Signature of Proposed Insured or Parent/Guardian

Date Signed

Name of Proposed Insured

Address



Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

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

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result _____

Address _____

In the event that the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test result as described above. I have read the information on this form about what a test result means.

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Signature of Proposed Insured or Parent/Guardian

Date Signed

Name of Proposed Insured

Address

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance



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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. 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.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.
3. 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.

The above Notice to Applicant was delivered to me on _____ Date

Applicant's Signature

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance



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

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Applicant's Signature