

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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



Application Submission Checklist To United of Omaha For Medicare Supplement and Whole Life Coverage – Texas

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

- Application**
 1. Complete “Medicare Supplement Plan Information” Box.
 2. Refer to the Medicare Supplement Outline of Coverage for policy forms.
 3. Answer all questions in full.
 4. Complete Whole Life Plan information, if applicable.
 5. Sign and Date in all places indicated.
 6. Be sure to leave all applicable forms with the proposed insured.
 7. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
 - The full modal premium is collected at the time of application.
 - Follow instructions on page 1 of **Calculate Your Premium form (M26617_TX)** to calculate the premium. Complete the form and return with the application.
- Provide Client with Medicare Supplement and Life Buyer’s Guide**
- Provide Client with Medicare Supplement Outline of Coverage**
- Complete Producer Information page**
- If applicable, complete the Authorization for Automatic Funds Withdraw form (ACH/BSP form M26618) and return with the completed application.**
- Provide Client with Conditional Receipt signed by agent**
- Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form U7869). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period. Please complete if applying for Whole Life insurance.**
- Complete Medicare Supplement Replacement Notice (U7565) and leave a copy with the applicant (if applicable)**
- Complete any applicable life replacement forms and leave a copy with the applicant**

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

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

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

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

1. Application – Agent Completes in Full: (please print)

“Medicare Supplement Plan Information” Box

- Medicare Supplement Policy Form
 - Requested Effective Date
 - Premium Collected (Amount) - Follow instructions on the Calculate Your Premium form (M26617_TX). Complete the form for the applicant(s) and return with the application.
 - Medicare Supplement Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
 - Medicare Supplement Renewal Premium (Amount)
 - Medicare Supplement Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
- *Direct Monthly billing not available

Section 1 “General Information”–

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant’s current age at time of application.
- The applicant’s Social Security number as indicated from applicant’s Social Security Card.
- For applicants already covered by Medicare, include applicant’s Medicare number on the application as indicated from the applicant’s Medicare Health Insurance Card. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent **must** provide this number by calling 1-877-617-5587 once it is received.
- The applicant’s current Height in feet and inches and Weight in pounds.
- The tobacco question must be answered if applying for life insurance

Sections 2 and 3 “Existing Medicare Supplement Coverage Information”–

- Please complete all questions in full.
- If the applicant is not covered by Medicare, indicate “Eligibility Date” and “Date of Enrollment”.
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
 - Name of Company
 - Issue Date
 - Policy/Certificate Number
 - Termination/Disenrollment Date
 - Plan
 - Kind of Policy

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

Section 4 “Health Questions”

- If applying for Medicare Supplement
 - During Open Enrollment or Guaranteed Issue period, skip Section 4 and go to Section 5
 - NOT during Open Enrollment or Guaranteed Issue period, please answer all questions
- If applying for Whole Life insurance, please answer all questions

Section 6 “Whole Life Plan Information”

- Please complete entire section
- Face amounts available in \$1,000 increments from \$2,500 to \$20,000
- Initial and Renewal payment modes must be the same for life insurance

2. Administrative Forms

Producer/Agent Information

- Be sure to include your Social Security number and commission code.
 - NOTE: This information is necessary for the underwriting process and commission payment.**
- Include your telephone number, e-mail address and FAX number for contact purposes.

Authorization for Automatic Funds Withdraw by United of Omaha Life Insurance Company (ACH/BSP) –

If applicant chooses to pay premium by ACH/BSP, complete entire form accurately and return with the application.

- **Option A** - Pay all premiums (1st & montly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium **MUST** be submitted with the application
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment. – **Available for Medicare Supplement only**

Conditional Receipt

- Complete, sign, detach and leave with applicant.

Authorization To Disclose Personal Information (HIPAA)

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.
- If client **IS** applying for Life insurance, complete the Authorization

Replacement Notice – complete if applicable for either Medicare Supplement or Life insurance

- Complete form including signature and date and leave copy with applicant (if applicable)

State-specific Forms – complete if applicable for either Medicare Supplement or Life insurance

UNITED OF OMAHA LIFE INSURANCE COMPANY

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Application For: Medicare Supplement Coverage Life Insurance



Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:
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MEDICARE SUPPLEMENT PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT	APPLICANT B
Policy Form	Policy Form
Requested Effective Date	Requested Effective Date
Medicare Supplement Premium Collected \$	Medicare Supplement Premium Collected \$
Initial Mode A, S, Q, B or ACH	Initial Mode A, S, Q, B or ACH
Renewal \$	Renewal \$
Renewal Mode A, S, Q, B (monthly not available)	Renewal Mode A, S, Q, B (monthly not available)

1. IF APPLYING FOR MEDICARE SUPPLEMENT AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____) (area code)	Home Phone No (_____) (area code)
Current Age _____ Date of Birth ____/____/____ mo / day / yr	Current Age _____ Date of Birth ____/____/____ mo / day / yr
Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security No.	Social Security No.
Medicare Health Insurance Card Number (if known or applicable)	Medicare Health Insurance Card Number (if known or applicable)
E-mail Address	E-mail Address
Height _____ Weight _____ Ft _____ In _____ Lbs _____	Height _____ Weight _____ Ft _____ In _____ Lbs _____
Have you used tobacco in any form in the past 12 months?Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you used tobacco in any form in the past 12 months?Yes <input type="checkbox"/> No <input type="checkbox"/>

2. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	APPLICANT Yes <input type="checkbox"/> No <input type="checkbox"/>	APPLICANT B Yes <input type="checkbox"/> No <input type="checkbox"/>
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant / Applicant B		
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ / _____ Applicant / Applicant B		
3. Did you turn age 65 in the last 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last 6 months? If "YES," indicate your effective date. _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

3. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES" please attach proof of eligibility.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____ / ____ / ____	Issue Date ____ / ____ / ____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If "YES," indicate termination date. _____ / _____ / _____ Applicant / Applicant B		
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ / _____ / _____ END _____ / _____ / _____ Applicant / Applicant B		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant / Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ / _____ Applicant / Applicant B		

4. IF APPLYING FOR MEDICARE SUPPLEMENT:

- During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.
- NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS.

If either you or Applicant B answer “YES” to any of the following questions 1-14, that person is not eligible for Medicare Supplement or Life Insurance coverage.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed with Parkinson’s Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered “NO”.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Within the past two years have you been treated for degenerative bone disease, crippling/ disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If “YES,” please list the drug and the condition in the following table.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

5. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE COMPLETE HOUSEHOLD DISCOUNT INFORMATION

You may be eligible for a policy with a lower rate based on your answers to the statements in this section. a. I have continuously resided with another person for the last 12 months or are married and they are also applying for this coverage. If "YES," please provide the following information. If you and Applicant B are applying for coverage on this application, do not fill out the following information.	Applicant	Applicant B
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Relationship to Applicant:

First Name _____

Last Name _____

Street Address _____

City _____ State _____ ZIP _____

b. I have continuously resided with another person for the last 12 months or are married and they have an existing Medicare supplement policy or certificate with Mutual of Omaha Insurance Company or United World Life Insurance Company or United of Omaha Life Insurance Company. If "YES," please provide the following information.	Applicant	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Relationship to Applicant:

First Name _____

Last Name _____

Street Address _____

City _____ State _____ ZIP _____

Policy/Certificate Number _____

6. IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Life Insurance, you must answer all the questions in Section 4 of the application.

APPLICANT	APPLICANT B (if applying for coverage)
Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)	Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)
Relationship to Applicant	Relationship to Applicant B
Face Amount: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____	Face Amount: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other _____
Life Insurance Premium Collected: \$	Life Insurance Premium Collected: \$
Mode: A, S, Q, B	Mode: A, S, Q, B

- | | | |
|--|--|--|
| | Applicant | Applicant B |
| | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
- Are you a citizen of the United States?
If "No," complete Foreign National and Foreign Travel Questionnaire
 - List below all life insurance policies and/or annuity contracts on the Applicants that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) **If none, check the following box:** None
 - List below if you have had or intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application.
The Producer shall comply with any additional state and/or company replacement requirements.

Company	Applicant	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

Dated at _____, on _____, _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____
City State Month Day Year Applicant B's Signature (if applying)

I wish to apply for a Life insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. The life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policy owner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the application, from the date the application is approved by United of Omaha's Underwriting Department to the date the policy is delivered and accepted by the policy owner.

Dated at _____, on _____, _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

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

(Signature of Licensed Producer)

(Signature of Licensed Producer)

PRODUCER STAMP

PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>

SECTION FOR ADDITIONAL COMMENTS

Applicant (please attach a separate sheet if needed)	Applicant B (please attach a separate sheet if needed)

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Calculate Your Initial Premium – Medicare Supplement and Whole Life Insurance

Before you begin: If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.

Medicare Supplement Plan

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
#1	Premium Write in your Med supp plan's premium from the Outline of Coverage provided.	\$128.52		
#2	Household Discount Are you eligible to receive a household discount? If yes, multiply line #1 by .93. If no, enter the amount from line #1.	\$128.52 x .93 = \$119.52 In this example, the person qualifies for the household discount.		
#3	Payment Options Your monthly payment is your last premium entered (line #2). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$119.52 monthly payment \$358.56 quarterly payment \$717.12 semiannual payment \$1,434.24 annual payment		

Whole Life Insurance

	Follow these steps to calculate premium.	Example (Male, age 65, Nontobacco, needs \$10,000 of coverage)	Applicant's Premium	Applicant B's Premium
#4	Locate your monthly rate in the chart provided on page 3.	\$63.92		
#5	Payment Options Your monthly payment is the premium entered in line #4. To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$63.92 monthly payment \$191.76 quarterly payment \$383.52 semiannual payment \$767.04 annual payment		

Total Medicare Supplement and Whole Life Initial Premium

#6	To determine your TOTAL initial premium add #3 and #5	\$183.44	\$	\$
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Complete and return with application

Height and Weight Chart

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Medicare supplement insurance is underwritten by
UNITED OF OMAHA LIFE INSURANCE COMPANY
 A MUTUAL of OMAHA COMPANY
 Mutual of Omaha Plaza
 Omaha, Nebraska 68175
 mutualofomaha.com
 Policy forms UM1-21189, UM4-21192, UM5-21193.

Whole Life Monthly Premiums

	Ages 64-69				Ages 70-74				Ages 75-79				Ages 80-85			
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
\$20,000.00 BENEFIT	Male \$124.83	Male \$201.40	Female \$94.60	Female \$131.97	Male \$172.92	Male \$277.92	Female \$123.08	Female \$196.03	Male \$237.00	Male \$352.68	Female \$176.48	Female \$269.03	Male \$331.32	Male \$427.43	Female \$279.72	Female \$356.23
\$19,000.00 BENEFIT	Male \$118.74	Male \$191.48	Female \$90.02	Female \$125.52	Male \$164.42	Male \$264.17	Female \$117.08	Female \$186.38	Male \$225.30	Male \$335.20	Female \$167.81	Female \$255.73	Male \$314.90	Male \$406.21	Female \$265.88	Female \$338.57
\$18,000.00 BENEFIT	Male \$112.65	Male \$181.56	Female \$85.44	Female \$119.07	Male \$155.93	Male \$250.43	Female \$111.08	Female \$176.73	Male \$213.60	Male \$317.72	Female \$159.14	Female \$242.43	Male \$298.49	Male \$384.99	Female \$252.05	Female \$320.91
\$17,000.00 BENEFIT	Male \$106.56	Male \$171.64	Female \$80.86	Female \$112.62	Male \$147.43	Male \$236.68	Female \$105.07	Female \$167.08	Male \$201.90	Male \$300.23	Female \$150.46	Female \$229.13	Male \$282.07	Male \$363.77	Female \$238.21	Female \$303.25
\$16,000.00 BENEFIT	Male \$100.47	Male \$161.72	Female \$76.28	Female \$106.17	Male \$138.93	Male \$222.93	Female \$99.07	Female \$157.43	Male \$190.20	Male \$282.75	Female \$141.79	Female \$215.83	Male \$265.65	Male \$342.55	Female \$224.37	Female \$285.59
\$15,000.00 BENEFIT	Male \$94.38	Male \$151.80	Female \$71.70	Female \$99.73	Male \$130.44	Male \$209.19	Female \$93.06	Female \$147.78	Male \$178.50	Male \$265.26	Female \$133.11	Female \$202.53	Male \$249.24	Male \$321.33	Female \$210.54	Female \$267.93
\$14,000.00 BENEFIT	Male \$88.28	Male \$141.88	Female \$67.12	Female \$93.28	Male \$121.94	Male \$195.44	Female \$87.06	Female \$138.12	Male \$166.80	Male \$247.78	Female \$124.44	Female \$189.22	Male \$232.82	Male \$300.10	Female \$196.70	Female \$250.26
\$13,000.00 BENEFIT	Male \$82.19	Male \$131.96	Female \$62.54	Female \$86.83	Male \$113.45	Male \$181.70	Female \$81.05	Female \$128.47	Male \$155.10	Male \$230.29	Female \$115.76	Female \$175.92	Male \$216.41	Male \$278.88	Female \$182.87	Female \$232.60
\$12,000.00 BENEFIT	Male \$76.10	Male \$122.04	Female \$57.96	Female \$80.38	Male \$104.95	Male \$167.95	Female \$75.05	Female \$118.82	Male \$143.40	Male \$212.81	Female \$107.09	Female \$162.62	Male \$199.99	Male \$257.66	Female \$169.03	Female \$214.94
\$11,000.00 BENEFIT	Male \$70.01	Male \$112.12	Female \$53.38	Female \$73.93	Male \$96.45	Male \$154.20	Female \$69.05	Female \$109.17	Male \$131.70	Male \$195.33	Female \$98.42	Female \$149.32	Male \$183.57	Male \$236.44	Female \$155.19	Female \$197.28
\$10,000.00 BENEFIT	Male \$63.92	Male \$102.20	Female \$48.80	Female \$67.48	Male \$87.96	Male \$140.46	Female \$63.04	Female \$99.52	Male \$120.00	Male \$177.84	Female \$89.74	Female \$136.02	Male \$167.16	Male \$215.22	Female \$141.36	Female \$179.62
\$9,000.00 BENEFIT	Male \$57.83	Male \$92.28	Female \$44.22	Female \$61.04	Male \$79.46	Male \$126.71	Female \$57.04	Female \$89.87	Male \$108.30	Male \$160.36	Female \$81.07	Female \$122.72	Male \$150.74	Male \$194.00	Female \$127.52	Female \$161.96
\$8,000.00 BENEFIT	Male \$51.73	Male \$82.36	Female \$39.64	Female \$54.59	Male \$70.97	Male \$112.97	Female \$51.03	Female \$80.21	Male \$96.60	Male \$142.87	Female \$72.39	Female \$109.41	Male \$134.33	Male \$172.77	Female \$113.69	Female \$144.29
\$7,000.00 BENEFIT	Male \$45.64	Male \$72.44	Female \$35.06	Female \$48.14	Male \$62.47	Male \$99.22	Female \$45.03	Female \$70.56	Male \$84.90	Male \$125.39	Female \$63.72	Female \$96.11	Male \$117.91	Male \$151.55	Female \$99.85	Female \$126.63
\$6,000.00 BENEFIT	Male \$39.55	Male \$62.52	Female \$30.48	Female \$41.69	Male \$53.98	Male \$85.48	Female \$39.03	Female \$60.91	Male \$73.20	Male \$107.91	Female \$55.05	Female \$82.81	Male \$101.50	Male \$130.33	Female \$86.02	Female \$108.97
\$5,000.00 BENEFIT	Male \$33.46	Male \$52.60	Female \$25.90	Female \$35.24	Male \$45.48	Male \$71.73	Female \$33.02	Female \$51.26	Male \$61.50	Male \$90.42	Female \$46.37	Female \$69.51	Male \$85.08	Male \$109.11	Female \$72.18	Female \$91.31
\$4,000.00 BENEFIT	Male \$27.37	Male \$42.68	Female \$21.32	Female \$28.79	Male \$36.98	Male \$57.98	Female \$27.02	Female \$41.61	Male \$49.80	Male \$72.94	Female \$37.70	Female \$56.21	Male \$68.66	Male \$87.89	Female \$58.34	Female \$73.65
\$3,000.00 BENEFIT	Male 21.28	Male 32.76	Female 16.74	Female 22.35	Male 28.49	Male 44.24	Female 21.01	Female 31.96	Male 38.10	Male 55.45	Female 29.02	Female 42.91	Male 52.25	Male 66.67	Female 44.51	Female 55.99

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Producer(s) Information

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

Producer Name _____ Social Security No _____
Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
Producer E-mail Address _____ @ _____
Producer FAX Number _____

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

Initial Payment

Is the applicant: Yes No

(a) unemployed?.....

(b) employed, but not working for the business that is paying the premium?

(c) the business owner or spouse of the business owner?

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

Renewal Payment

Is the applicant: Yes No

(a) unemployed?.....

(b) employed, but not working for the business that is paying the premium?

(c) the business owner or spouse of the business owner?

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

Required if applying for Life Insurance:

Reviewed By: _____
(Division Office, BGA, Bank Name)

(DSM, Assistant Wholesaler or Authorized Reviewer's Printed Name)

Agency Stamp	DSM Stamp
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Authorization for Automatic Funds Withdraw (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

	Applicant		Applicant B	
	YES	NO	YES	NO
Medicare Supplement Premium Payment Options:				
a. Pay all premiums (1st month and monthly renewals) by ACH/BSP.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pay 1st premium by paper check and pay monthly renewals by BSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pay initial premium by ACH and pay renewals by direct bill (monthly direct billing is not offered)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected below.

List amount of initial premium payment withdrawal, if applicable \$ _____ \$ _____

Life Insurance Premium Payment Options:

a. Pay all premiums (1st month and monthly renewals) by ACH/BSP.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pay 1st premium by paper check and pay monthly renewals by BSP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Withdrawal date of the initial premium payment will occur only if and when coverage is approved for issue and may be different than the monthly withdrawal date selected below

Withdrawal date for monthly renewal payments, if applicable (circle one)..... 1st or 15th 1st or 15th

Is a Business Account being used to pay premiums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, is the applicant:				
(a) Unemployed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Employed, but not working for the business that is paying the premium.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) The business owner or spouse of the business owner.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If (a), (b), or (c) are "Yes," premiums CAN be paid with a business account

Applicant/Owner

Account Type (check one): Checking Savings
Complete information below or attach a voided check.

 Name of Financial Institution

 Routing Number (first 9 digits on lower left side of check)

 Account Number

 Name as Shown on Account

Applicant/Owner B (if applicable)

Account Type (check one): Checking Savings
Complete information below or attach a voided check.

 Name of Financial Institution

 Routing Number (first 9 digits on the lower left side of check)

 Account Number

 Name as Shown on Account

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize United of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to United of Omaha. Your rights with each charge will be the same as if personally paid by me. The 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.

 Authorized Signature as Shown on Account

 Date

 Authorized Signature as Shown on Account

 Date

Instructions for Completion of Authorization for Automatic Funds Withdraw (ACH/BSP) Form

The applicant may select one of three payment options indicated on the front side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by ACH/BSP

When choosing to pay both the initial and monthly renewals by ACH/BSP, the applicant must complete the form and submit it with the application. DO NOT submit a check for payment, however, a voided check may be submitted in lieu of completing the account information (account/routing numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered) – Medicare Supplement only – not available for life insurance

When choosing to pay the initial premiums by ACH and renewal premiums by direct billing, the applicant must complete the form and submit it with the application. DO NOT submit a check for the initial premium payment, however, a voided check may be submitted in lieu of completing the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premiums by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the ACH/BSP form accurately and in its entirety, making sure that all required information is correct and complete on your ACH/BSP form prior to submission. In addition, please make sure that the premium amount is filled in on the ACH/BSP form, so we can initiate a timely and accurate withdrawal from your client's bank account.

Below is an example of how to find correct Routing and Account Numbers on your clients' checks. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

The diagram shows a check form with the following fields and callouts:

- Account Holder Name:** A callout box pointing to the top left of the form.
- Check Number:** A callout box pointing to the top right of the form.
- Form Fields:**
 - John Doe
 - Street Address
 - Town, City Zip code
 - Date: _____
 - Pay to: _____
 - _____ Dollars
 - Bank Name & Address
 - Memo _____
 - Signed By: _____
 - 1: 123456789:1 12345678 11* 1234 11*
- Bank Routing/Transfer Number:** A callout box pointing to the first part of the MICR line.
- Bank Account Number:** A callout box pointing to the second part of the MICR line.
- Check Number (if shown at bottom, may be shown before or after the account #):** A callout box pointing to the third part of the MICR line.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Conditional Receipt

Check or Money Order Application

All premiums must be made payable to the United of Omaha Life Insurance Company.

Do not make check or money order payable to the agent or leave the payee blank.

Applicant/Owner

Received of _____
this _____ day of _____,

an application for Form _____ Policy
and/or Riders _____ and
Check or Money Order for _____ Dollars.

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

Agent _____

Applicant/Owner B (if applicable)

Received of _____
this _____ day of _____,

an application for Form _____ Policy
and/or Riders _____ and
Check or Money Order for _____ Dollars.

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

Agent _____

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

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

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

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

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Authorization To Disclose Personal Information To United of Omaha Life Insurance Company

Meanings of Terms

“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 Specified Companies to share personal information about me. Personal information includes information about the products I have applied for and been issued and 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.

The Personal Information will be used to determine my eligibility for other insurance products and to provide me information about those products.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, I may not receive information about other products I am eligible for.

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
United of Omaha Life 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 the Specified Companies have taken action in reliance on the authorization.

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): _____

Applicant/Owner	Applicant/Owner B (if applicable)
Printed Name of Proposed Applicant	Printed Name of Proposed Applicant
Signature of Proposed Applicant	Signature of Proposed Applicant
Date	Date

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United of Omaha Life Insurance Company. Your new policy will provide 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. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

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

Applicant	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan
<input type="checkbox"/> Please explain reason for disenrollment	<input type="checkbox"/> Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

1. Health conditions which you may presently have 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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you 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 and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Signature of Agent, Broker or Other Representative*

UNITED OF OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by United of Omaha Life Insurance Company. Your new policy will provide 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. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

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

Applicant	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan
<input type="checkbox"/> Please explain reason for disenrollment	<input type="checkbox"/> Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

1. Health conditions which you may presently have 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. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you 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 and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Signature of Agent, Broker or Other Representative*

UNITED OF OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Medicare Select Policy Disclosure Agreement

I acknowledge receipt of the following information:

1. Outline of Coverage
2. Description of the restricted network provisions including:
 - (a) network providers;
 - (b) payments for coinsurance and deductibles when providers other than network providers are utilized;
 - (c) coverage for emergency and urgently needed care and other out of service area coverage;
 - (d) limitations on referrals to restricted network providers;
 - (e) description of my rights to purchase a Medicare supplement policy of equal or lesser benefits offered in my state by United of Omaha;
 - (f) United of Omaha Life Insurance Company's Quality Assurance Program; and
 - (g) United of Omaha Life Insurance Company's Grievance Procedures.

I also understand the following:

United of Omaha does not recommend the purchase of a Medicare select policy if I live more than 20-25 miles from a network hospital; unless the network hospital is the closest hospital which offers this level of service.

I have received full and fair disclosure of the information described above.

Signature of the Proposed Applicant	Signature of the Proposed Applicant B
Date	Date

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Definition of Eligible Person for Guaranteed Issue

The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

- (a) Enrolled under an employee welfare benefit plan and the plan terminates or ceases to provide benefits or the individual is no longer eligible for the plan;
- (b) Enrolled in a Medicare+Choice plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare+Choice, a risk or choice contract, or a Medicare Select plan and then the insured person terminates coverage within 12 months of enrollment, or
- (f) Upon first becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare+Choice or in a PACE Program and disenrolls within 12 months.

If any of the definitions apply to you, please complete the Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

Notice: You have the right to return the policy within 30 days of delivery and receive an unconditional full refund of all premiums or considerations paid on it including any policy fees or charges. In the case of a variable or market value adjustment policy, you will receive the cash surrender value plus any fees or other charges deducted from the gross premiums or considerations.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

- | | | |
|--|--|--|
| | Applicant/Owner | Applicant/Owner B |
| 1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

Applicant/Owner

Insurer Name	Contract or Policy #	Insured	Replaced (R) or Financing (F)

Applicant/Owner B (if applicable)

Insurer Name	Contract or Policy #	Insured	Replaced (R) or Financing (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

Applicant/Owner

Applicant/Owner B (if applicable)

I certify that the responses herein are, to the best of my knowledge are accurate.

Applicant

Applicant B (if applicable)

Printed Name of Proposed Applicant/Owner	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date

Producer's Signature

Printed Name/Date

I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

Applicant/Owner _____

Applicant/Owner B (if applicable) _____

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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Applicant/Owner B (if applicable)

Insurer Name	Contract or Policy #	Insured	Replaced (R) or Financing (F)

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Applicant/Owner

Applicant/Owner B (if applicable)

I certify that the responses herein are, to the best of my knowledge are accurate.

Applicant	Applicant B (if applicable)
Printed Name of Proposed Applicant/Owner	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date

Producer's Signature

Printed Name/Date

I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

Applicant/Owner _____

Applicant/Owner B (if applicable) _____

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Replacement Analysis Form

Replacement Determination

Replacement of life insurance or an annuity policy is taking place if, following purchase of this new coverage, any existing coverage will be:

- (1) lapsed, surrendered, partially surrendered, withdrawn upon, terminated, or assigned to the insurer
- (2) changed or modified into paid-up insurance or continued as extended term insurance
- (3) reduced with respect to benefits, premiums, or the period of time it will be in force
- (4) reissued with a reduction in face amount
- (5) borrowed against
- (6) used to finance the proposed policy (by surrender, withdrawal or loan against any existing policy to pay premiums on the new policy)

United of Omaha requires information be provided to the Applicant to compare a new life insurance policy or annuity contract with existing coverage, to determine if a replacement is desired. (There may be additional forms required by the state). **The Applicant should discuss the information in detail with the Producer, and carefully weigh the advantages and disadvantages of both policies.**

NOTICE TO APPLICANT: Replacing an existing life insurance policy with a new one may not be in your best interest. It is important that you compare the advantages and disadvantages of this replacement, and ask questions when you do not understand.

Replacement Analysis

Insurer Name	Policy or Contract Number	Type of Policy: Term (T) or Permanent (P)	Check box if used to finance proposed policy
Applicant/Owner			
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>
Applicant/Owner B (if applicable)			
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>

The following provisions have been discussed (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> annual premium | <input type="checkbox"/> face amount | <input type="checkbox"/> tax treatment of rollovers* |
| <input type="checkbox"/> suicide exclusion provision | <input type="checkbox"/> contestability provision | <input type="checkbox"/> underwriting classification |
| <input type="checkbox"/> guaranteed death benefit | <input type="checkbox"/> guaranteed interest rate | <input type="checkbox"/> guaranteed cash values |
| <input type="checkbox"/> surrender charge period and amount | <input type="checkbox"/> expense charges | <input type="checkbox"/> riders |
| <input type="checkbox"/> loan provision and loan interest rate | <input type="checkbox"/> current interest rate | <input type="checkbox"/> other _____ |

*The applicant should consult a qualified tax advisor regarding money rolled over from one policy to another.

The primary reason the new policy or contract is to be issued is (please be specific):

Applicant/Owner

Applicant/Owner B (if applicable)

Name of Producer

Signature of Producer

Date

I hereby certify that I have considered the above information, and understand the effects of replacing my life insurance.

Applicant/Owner

Applicant/Owner B (if applicable)

Printed Name of Proposed Applicant/Owner	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date
Address of Applicant/Owner	Address of Applicant/Owner
City, State, ZIP Code	City, State, ZIP Code

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Replacement Analysis Form

Replacement Determination

Replacement of life insurance or an annuity policy is taking place if, following purchase of this new coverage, any existing coverage will be:

- (1) lapsed, surrendered, partially surrendered, withdrawn upon, terminated, or assigned to the insurer
- (2) changed or modified into paid-up insurance or continued as extended term insurance
- (3) reduced with respect to benefits, premiums, or the period of time it will be in force
- (4) reissued with a reduction in face amount
- (5) borrowed against
- (6) used to finance the proposed policy (by surrender, withdrawal or loan against any existing policy to pay premiums on the new policy)

United of Omaha requires information be provided to the Applicant to compare a new life insurance policy or annuity contract with existing coverage, to determine if a replacement is desired. (There may be additional forms required by the state). **The Applicant should discuss the information in detail with the Producer, and carefully weigh the advantages and disadvantages of both policies.**

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Replacement Analysis

Insurer Name	Policy or Contract Number	Type of Policy: Term (T) or Permanent (P)	Check box if used to finance proposed policy
Applicant/Owner			
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>
Applicant/Owner B (if applicable)			
1. _____	_____	_____	<input type="checkbox"/>
2. _____	_____	_____	<input type="checkbox"/>
3. _____	_____	_____	<input type="checkbox"/>

The following provisions have been discussed (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> annual premium | <input type="checkbox"/> face amount | <input type="checkbox"/> tax treatment of rollovers* |
| <input type="checkbox"/> suicide exclusion provision | <input type="checkbox"/> contestability provision | <input type="checkbox"/> underwriting classification |
| <input type="checkbox"/> guaranteed death benefit | <input type="checkbox"/> guaranteed interest rate | <input type="checkbox"/> guaranteed cash values |
| <input type="checkbox"/> surrender charge period and amount | <input type="checkbox"/> expense charges | <input type="checkbox"/> riders |
| <input type="checkbox"/> loan provision and loan interest rate | <input type="checkbox"/> current interest rate | <input type="checkbox"/> other _____ |

*The applicant should consult a qualified tax advisor regarding money rolled over from one policy to another.

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Applicant/Owner

Applicant/Owner B (if applicable)

Name of Producer

Signature of Producer

Date

I hereby certify that I have considered the above information, and understand the effects of replacing my life insurance.

Applicant/Owner

Applicant/Owner B (if applicable)

Printed Name of Proposed Applicant/Owner	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date
Address of Applicant/Owner	Address of Applicant/Owner
City, State, ZIP Code	City, State, ZIP Code

United of Omaha Life Insurance – 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. Upon request, 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 the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

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: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Investigative Consumer Reports Notice

United of Omaha Life 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.

GIVE THIS NOTICE TO THE APPLICANT