Omaha Supplement Insurance Co. Application Packet

Thank you for your interest in the Omaha Supplement Insurance Company Medicare Supplement plan!

This application packet provides you with a link to the Online Application to submit your application directly to Omaha Supplement Insurance Company, directions about how to access a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to United World Life. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) **Online Application** Download Policy Outline (.pdf) Download Application Download (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Texas

Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or are changing brokerage firms
Tiffany Jackson	0 5 2 3 1 0 3	100 %	
		%	

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☑ Email Contact info: _____

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – Omaha Supplemental Ins. Co. Medicare Supplement/Select Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Household Premium Discount Information
- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question 7 OR BOTH questions 8 and 9 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section I: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section K: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Calculate Your Premium form**
- The full modal premium is collected at the time of application

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

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable)**

☐ **Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice**

Note: An interviewer may call to verify/confirm the information provided on the application.
This form is required if splitting commissions.

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Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:
(Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

- *If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*
- *If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.*

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility (Can vary by situation, refer to Underwriting Guide):

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)
g. Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

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Mutual of Omaha

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan

Applicant A _____

Applicant B _____

Before you begin: *Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.*

	Steps	Example Sample rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 78798		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$98.10		
#3	**Household Premium Discount** Please refer to the application for state specific household discount premium rules. **If the rules apply,** multiply the amount from Step #2 by .88. **If the rules do not apply,** enter the amount from Step #2.	$98.10 x .88 = $86.33 In this example, the person qualifies for the household premium discount.		
#4	**Rate Adjustment** *If you're in your open enrollment or guaranteed issue period, skip to Step #5.* **Locate your height, then weight, on the next page.** • If your weight is in the Standard column, enter the amount from Step #3 • If your weight is in a Decline column, you are ineligible for coverage.			
#5	**Payment Options** Your monthly payment is your last premium entered (Step #3 or #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)	$86.33 monthly payment $258.98 quarterly payment $517.98 semiannual payment $1,035.96 annual payment		

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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2''	‹ 54	55 – 145	146 +
4' 3''	‹ 56	57 – 151	152 +
4' 4''	‹ 58	59 – 157	158 +
4' 5''	‹ 60	61 – 163	164 +
4' 6''	‹ 63	64 – 170	171 +
4' 7''	‹ 65	66 – 176	177 +
4' 8''	‹ 67	68 – 182	183 +
4' 9''	‹ 70	71 – 189	190 +
4' 10''	‹ 72	73 – 196	197 +
4' 11''	‹ 75	76 – 202	203 +
5' 0''	‹ 77	78 – 209	210 +
5' 1''	‹ 80	81 – 216	217 +
5' 2''	‹ 83	84 – 224	225 +
5' 3''	‹ 85	86 – 231	232 +
5' 4''	‹ 88	89 – 238	239 +
5' 5''	‹ 91	92 – 246	247 +
5' 6''	‹ 93	94 – 254	255 +
5' 7''	‹ 96	97 – 261	262 +
5' 8''	‹ 99	100 – 269	270 +
5' 9''	‹ 102	103 – 277	278 +
5' 10''	‹ 105	106 – 285	286 +
5' 11''	‹ 108	109 – 293	294 +
6' 0''	‹ 111	112 – 302	303 +
6' 1''	‹ 114	115 – 310	311 +
6' 2''	‹ 117	118 – 319	320 +
6' 3''	‹ 121	122 – 328	329 +
6' 4''	‹ 124	125 – 336	337 +
6' 5''	‹ 127	128 – 345	346 +
6' 6''	‹ 130	131 – 354	355 +
6' 7''	‹ 134	135 – 363	364 +
6' 8''	‹ 137	138 – 373	374 +
6' 9''	‹ 140	141 – 382	383 +
6' 10''	‹ 144	145 – 392	393 +
6' 11''	‹ 147	148 – 401	402 +
7' 0''	‹ 151	152 – 411	412 +
7' 1''	‹ 155	156 – 421	422 +
7' 2''	‹ 158	159 – 431	432 +
7' 3''	‹ 162	163 – 441	442 +
7' 4''	‹ 166	167 – 451	452 +

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DNIS _____ Auth # _____

Agent Writing # 0 5 2 3 1 0 3 Group # (if applicable) _____ Keyline _____

MUTUAL of OMAHA

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

How Did You Hear About Us?

Please select all that apply. Thank you for providing this helpful information.

☑ Agent/Broker/Producer ☐ Family Member/Friend ☐ Physician Referral ☐ Social Media
☐ Direct Mail ☐ Internet Search ☐ Radio ☐ TV

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): ☐ Plan A ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, this **additional** plan is an available option: ☐ Plan F	**Plan (select one):** ☐ Plan A ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, this **additional** plan is an available option: ☐ Plan F
Requested Effective Date ☐☐ / ☐☐ / ☐☐☐☐	**Requested Effective Date** ☐☐ / ☐☐ / ☐☐☐☐
Deliver Policy to: Applicant A ☐ Producer ☐	**Deliver Policy to:** Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
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 ☐☐☐ – ☐☐☐ – ☐☐☐☐ (area code)	Home Phone ☐☐☐ – ☐☐☐ – ☐☐☐☐ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ mo day yr	Current Age _____ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ mo day yr

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B. Applicant Information (Continued)

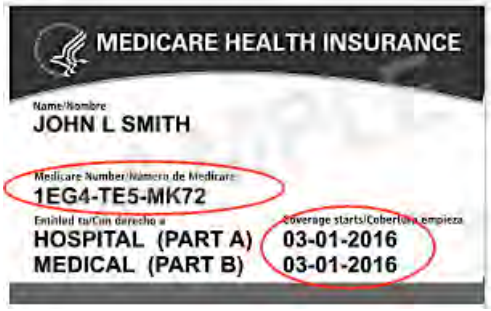
Applicant A	Applicant B
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Y ☐ N	Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Y ☐ N

Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Omaha Supplemental Insurance Company.

Receive statement online? ☐ Y ☐ N	Receive statement online? ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____	Medicare Part A Effective Date ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____
Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____	Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant B**
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months and who is an adult; or (b) with whom you reside and to whom you are married?	☐ Y ☐ N	☐ Y ☐ N

2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)
Date of Birth
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

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 certificate, or that you had certain rights to buy such a policy or certificate, 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.

To the Best of Your Knowledge and Belief:	**Applicant A**	**Applicant B**
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	☐ Y ☐ N	☐ Y ☐ N

(b) Indicate planned termination or disenrollment date..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

(c) With what company, and what plan do you have?

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	**Applicant B**
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)...	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(c) Planned date of termination/disenrollment?..... Applicant A ☐☐/☐☐/☐☐☐☐		
Applicant B ☐☐/☐☐/☐☐☐☐		
(d) Was this your first time in this type of Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(f) Is your former Medicare supplement or Medicare Select policy/certificate still available?	☐ Y ☐ N	☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:	Check box(s) below if applicable Applicant A	Applicant B
■ Your Medicare Advantage plan is leaving the Medicare program	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan	☐	☐

■ Other: _____
Applicant A

_____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank..... Applicant A START __/__/____
END __/__/____
Applicant B START __/__/____
END __/__/____

(b) Planned date of termination/disenrollment?..... Applicant A __/__/____
Applicant B __/__/____

(c) Have you disenrolled from your current coverage voluntarily?	☐ Y ☐ N	☐ Y ☐ N

(d) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

(e) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you applying during an open enrollment period?		
(a) Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
(b) Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A __/__/____
Applicant B __/__/____

8. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N

STOP **IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.**

If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS G & H and GO TO SECTION I.

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information

For all plans, answer questions 9-19. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
11. Have you been medically diagnosed with, treated for, or had surgery for any of the following (Do not include surgery when answering G):		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	☐ Y ☐ N	☐ Y ☐ N
12. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Y ☐ N	☐ Y ☐ N
13. Do you have Osteoporosis, and as a result, experienced a fracture?	☐ Y ☐ N	☐ Y ☐ N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	☐ Y ☐ N	☐ Y ☐ N
15. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N

Part B: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement?	☐ Y ☐ N	☐ Y ☐ N
17. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)?	☐ Y ☐ N	☐ Y ☐ N
B. Had any changes in your medications within the past two years?	☐ Y ☐ N	☐ Y ☐ N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
19. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N

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NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.

H. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
20. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	☐ Y ☐ N	☐ Y ☐ N

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

SA6035-41

I. Agreement and Authorization

IMPORTANT STATEMENTS

- 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 coverages.
- If you are age 65 or older, 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 reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO OMAHA SUPPLEMENTAL INSURANCE COMPANY

- I authorize any physician, 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, the group of companies which presently includes Omaha Insurance Company, United World Life Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Omaha Supplemental Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Omaha Supplemental Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Omaha Supplemental Insurance Company has taken action in reliance on the authorization or the law allows Omaha Supplemental Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are 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.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- 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.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. 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 Omaha Supplemental Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

SA6035-41

✍ Dated at _____, on ☐☐/☐☐/☐☐☐☐ _____
City State Month Day Year Applicant A's Signature

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

J. Producer Comments (please attach a separate sheet if needed)

K. To be Completed by Producer

21. Producers shall list any other health insurance policies/certificates sold to the applicant(s).
(a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant(s)..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant(s)..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

✍ _____
Signature of Licensed Producer Date

Tiffany Jackson
Printed Name

0	5	2	3	1	0	3

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

Printed Name

Agent Writing Number

SA6035-41

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ **Initial premium amount** (based on age at application date).....	$ _____.__	$ _____.__
1. Paper Check (submit signed check with application).....	☐	☐
(California collect only one month's premium at time of application)		
2. Automatic Bank Account Withdrawal.....	☐	☐
Ongoing Premium Payments (Select option #1a, #1b, or #2)		
1. I want my payments automatically withdrawn from my bank		
a. Choose the day payments will be deducted every month from your bank account.....	1st through the 28th or the last day of every month	1st through the 28th or the last day of every month
OR		
b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____	**Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.

Part II. Payor Information

	Applicant A	Applicant B
1. **Account Owner Name**, if different than applicant's.....	_____	_____
2. If premium is **NOT** paid by Proposed Insured/Insured (**includes spouse or joint-married account**), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.		
Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	☐	☐
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

S454216_1219

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

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

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

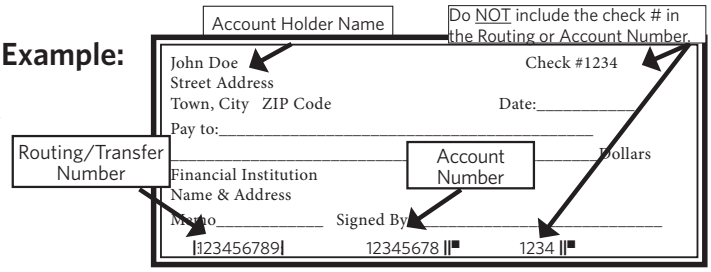
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



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

Applicant A

✍ _____
Authorized Signature as Shown on Account

_____
Date

Applicant B

✍ _____
Authorized Signature as Shown on Account

_____
Date

S454216_1219

Mutual of Omaha

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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 Omaha Supplemental 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 and acceptance by the replacing issuer, 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 the benefits provided under 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 A	**Applicant B**
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
☐ Other (please specify)	☐ 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 or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✍ _____ _____
Signature of Agent, Broker or Other Representative* **Date**

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

Applicant A	**Applicant B**
Signature ✍	Signature ✍
Date	Date

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S454171_0619_TX

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

Replacement Notice
If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Definition of Eligible Person for Guaranteed Issue
Premium Receipt

Mutual of Omaha

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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 Omaha Supplemental 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 and acceptance by the replacing issuer, 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 the benefits provided under 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 A	**Applicant B**
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
☐ Other (please specify)	☐ 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 or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✍ _____ _____
Signature of Agent, Broker or Other Representative* **Date**

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

Applicant A	**Applicant B**
Signature ✍	Signature ✍
Date	Date

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S454171_0619_TX

Mutual of Omaha

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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 Advantage 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 Advantage, 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 Advantage or in a PACE Program and disenrolls within 12 months.

(g) Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminated enrollment in the Medicare supplement policy.

(h) Loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

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.

S455649

S455649

Mutual of Omaha

Underwritten by
Omaha Supplemental Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Premium Receipt

All premiums must be made payable to Omaha Supplemental Insurance Company.

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

Applicant A

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

Applicant B

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Omaha Supplemental Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.

Provide the completed premium receipt, if applicable.

S454228_0619

S454228_0619

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

APPLICATION for

INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

TEXAS

MAP642_TX
01/16/2019

MUTUAL OF OMAHA INSURANCE COMPANY
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Monthly Rates (Issue Age 19-99)

TEXAS			
ZIP Codes	**Mutual Dental Preferred DNT2**	**Mutual Dental Protection DNT5**	**Vision Rider 0PD1M-41**
754-759, 764, 768, 776-781, 783-785, 790, 791, 793-799	$43.66	$24.96	$8.28
760-763, 765-767, 769, 770, 774, 775, 782, 788, 789, 792	$49.06	$28.05	$8.28
733, 750-753, 771-773, 786, 787, 885	$50.53	$28.89	$8.28

Rates Subject to Change.

As of 10/7/2017

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to $50 every calendar year for one eye exam (no waiting period)
Up to $150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

MUTUAL OF OMAHA INSURANCE COMPANY
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Internal Tracking Code _____
Group # (if applicable) _____

Mutual of Omaha

Application for Individual Dental Insurance with Optional Vision Rider

A. Applicant Information

Name (First, Middle Initial, Last)	Phone Number Home Cell	
Residence Address (Street, City, State, ZIP)	E-mail	
Mailing Address (Street, City, State, ZIP) (if different from residence address)	Deliver Policy to ☐ Applicant ☐ Producer	
Gender ☐ Male ☐ Female	Date of Birth	Social Security Number

B. Plan Information

Select Dental Benefit Plan ☐ Mutual Dental Preferred Annual Maximum $1,500 ☐ Mutual Dental Protection Annual Maximum $1,000	**Requested Effective Date** _____ **Monthly Premium Rate for Dental $** _____
☐ Optional Vision Rider (only available with Dental)	**Monthly Premium Rate for Vision $** _____
	Total Monthly Premium $ _____

C. Existing Coverage Information

Are you covered by any other dental or vision insurance? ☐ Y ☐ N

If Yes, answer the following about this existing coverage:

Name of dental carrier(s) _____

Name of vision carrier(s) _____

Is the coverage you are applying for replacing existing dental insurance? ☐ Y ☐ N

Is the coverage you are applying for replacing existing vision insurance? ☐ Y ☐ N

D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

✍ _____ _____
Applicant Signature Date Signed at City State

I/We acknowledge that if the applicant is replacing coverage, I/We have provided a copy of the replacement notice, if applicable.

✍ _____
Signature of Licensed Insurance Producer Date

Tiffany Jackson _____ 0 5 2 3 1 0 3 _____ 100 _____ %
Printed Name Agent Writing Number Comm. % Share

✍ _____
Signature of Licensed Insurance Producer Date

_____ _____ _____ %
Printed Name Agent Writing Number Comm. % Share

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)

✍ **Initial premium amount** (based on age at application date)..... $ ☐☐☐☐☐.☐☐

1. Paper Check (submit signed check with application)..... ☐
2. Automatic Bank Account Withdrawal..... ☐

Ongoing Premium Payments (Select option #1a, #1b, or #2)

1. I want my payments automatically withdrawn from my bank
   a. Choose the day payments will be deducted every month from your bank account..... 1st through the 28th or the last day of every month

   OR

   b. Choose the week and weekday that payments will be deducted every month from your bank account..... **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____
   (For Example: 3rd Wednesday of every month)

2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing)..... **every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

1. **Account Owner Name,** if different than applicant's..... _____
2. If premium is **NOT** paid by Proposed Insured/Insured **(includes spouse or joint-married account)**, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.

Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) ☐

Living Trust ☐

Power of Attorney or legal guardian (documentation required) ☐

Business owned by applicant or applicant's spouse ☐

M44903_0119

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

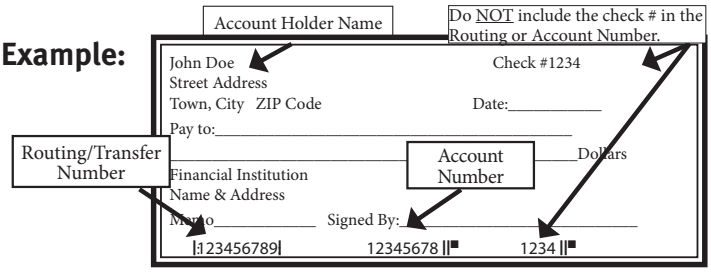
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



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

Applicant A

Authorized Signature as Shown on Account

Date

M44903_0119

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
3300 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 that 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 present 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 also in your best interests 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, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Mutual of Omaha Insurance Company within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

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
3300 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 that 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 present under the new policy, whereas a similar claim might have been payable under your present policy.

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

_____
Applicant's Signature

MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

LIMITED BENEFIT DENTAL COVERAGE ONLY

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

INDIVIDUAL DENTAL NETWORK INSURANCE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a network dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/dental-insurance.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	$50.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	50%
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	1 Year

MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	**$1,500.00**
Implant Lifetime Maximum Benefit	**$3,000.00**

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

Waiting Period – Class III covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;

(c) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(d) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(e) services or treatment performed prior to the policy effective date;
(f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
(h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(i) telephone consultations;
(j) any charges for failure to keep a scheduled appointment;
(k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(l) fluoride treatments;
(m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(n) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(o) office infection control charges;

(p) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(q) state, federal, or territorial taxes on dental services performed;
(r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(u) those dental services which are for specialized procedures and techniques;
(v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(w) duplicate, provisional and temporary devices, appliances, and services;
(x) plaque control programs, oral hygiene instruction, and dietary instructions;
(y) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(z) gold foil restorations;
(aa) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(cc) charges by the provider for completing dental forms;
(dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ee) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(ff) sealants;
(gg) precision attachments, personalization, precious metal bases and other specialized techniques;
(hh) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(ii) repair of damaged orthodontic appliances;
(jj) replacement of lost or missing appliances;
(kk) fabrication of athletic mouth guard;
(ll) internal bleaching;
(mm) nitrous oxide;
(nn) oral sedation;
(oo) topical medicament carrier;
(pp) orthodontic services, treatment or supplies, including braces and retainers;
(qq) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;

3. non-covered/non-eligible implants;

(rr) tooth whitening;
(ss) occlusal guards;
(tt) space maintainers;
(uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium when it is due.

Grace Period – Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period.

Premiums Can Change – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Total premium amount _____

MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

LIMITED BENEFIT DENTAL COVERAGE ONLY

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

INDIVIDUAL DENTAL NETWORK INSURANCE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a network dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/dental-insurance.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services, Class II – Basic Services and Class III – Major Services Combined	$100.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	50%
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	1 Year
MAXIMUM BENEFIT	**AMOUNT**

Annual Maximum Benefit per Calendar Year	**$1,000.00**
Implant Lifetime Maximum Benefit	**$2,000.00**

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

Waiting Period – Class III covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(d) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(e) services or treatment performed prior to the policy effective date;
(f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
(h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(i) telephone consultations;
(j) any charges for failure to keep a scheduled appointment;
(k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(l) fluoride treatments;
(m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(n) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(o) office infection control charges;

(p) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(q) state, federal, or territorial taxes on dental services performed;
(r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(u) those dental services which are for specialized procedures and techniques;
(v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(w) duplicate, provisional and temporary devices, appliances, and services;
(x) plaque control programs, oral hygiene instruction, and dietary instructions;
(y) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(z) gold foil restorations;
(aa) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(cc) charges by the provider for completing dental forms;
(dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ee) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;
(ff) sealants;
(gg) precision attachments, personalization, precious metal bases and other specialized techniques;
(hh replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(ii) repair of damaged orthodontic appliances;
(jj) replacement of lost or missing appliances;
(kk) fabrication of athletic mouth guard;
(ll) internal bleaching;
(mm)nitrous oxide;
(nn) oral sedation;
(oo) topical medicament carrier;
(pp) orthodontic services, treatment or supplies, including braces and retainers;
(qq bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;

3. non-covered/non-eligible implants;

(rr) tooth whitening;
(ss) occlusal guards;
(tt) space maintainers;
(uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before it is due.

Grace Period – Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period.

Premiums Can Change – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Total premium amount _____