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 Coverage – SOUTH CAROLINA

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

☐ **Application**

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

☐ **Collect Premium Amount**

- The full modal premium is collected at the time of application.
- Follow instructions on page 1 of **Calculate Your Premium form (UC6582_0208)** to calculate the premium. Complete the form and return with the application.

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

☐ **Provide Client with Outline of Coverage**

☐ **Complete Producer Information page**

☐ **If applicable, complete the Authorization for Automatic Funds Withdraw form (ACH/BSP form U7535_0608) 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 U7566). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**

☐ **Complete Replacement Notice (U7564) and leave a copy with the applicant (if applicable)**

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

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

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

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

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

"Plan Information" Box

- Policy Form
- Requested Effective Date
- Premium Collected (Amount) - Follow instructions on page 1 of Calculate Your Premium form (UC6582_0208) to calculate the premium. Complete the form for Applicants A & B (if applying) return with the application.
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
- Renewal Premium (Amount)
- 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.

Sections 2 and 3 "Existing 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
  – Policy/Certificate Number
  – Plan
  – Issue Date
  – Termination/Disenrollment Date
  – Kind of Policy

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

2. Administrative Forms

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 this form accurately and in its entirety 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.

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.

Replacement Notice – complete if applicable

- Complete form including signature and date.
- Leave a copy with applicant (if applicable).

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Application For Medicare Supplement Coverage

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By

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
Premium Collected $	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. PLEASE READ THE FOLLOWING CAREFULLY AND 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 ☐ Female ☐	Male ☐ Female ☐
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	Applicant	Applicant B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☐	Yes ☐ No ☐
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part A effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," what is your eligibility date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
2. Are you covered under Medicare Part B?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part B effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," indicate date you plan to enroll. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
3. Did you turn age 65 in the last 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," indicate your effective date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

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. 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 ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

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 ☐ No ☐	Yes ☐ No ☐
(c) If "YES," indicate termination date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions [(a-f)] [(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 ____/____/____ (Applicant) END ____/____/____ / START ____/____/____ (Applicant B) END ____/____/____		
(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 ☐ No ☐	Yes ☐ No ☐
(b) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐
(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)		
(d) Planned date of termination/disenrollment? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

	Applicant	Applicant B
(e) Was this your first time in this type of Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan)	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company and what kind of policy? (List below)		

Applicant		Applicant B	
Name of Company	Kind of Policy	Name of Company	Kind of Policy

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

(c) Reason for termination/disenrollment? _____ / _____
Applicant Applicant B

(d) Planned date of termination/disenrollment? _____/____/_____ / _____/____/_____
Applicant Applicant B

	Applicant	Applicant B
5. 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.) If "YES,"	Yes ☐ No ☐	Yes ☐ No ☐
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes ☐ No ☐	Yes ☐ No ☐
6. Producers shall list any other health insurance policies they have sold to the applicant.		
(a) List policies sold which are still in force.		

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

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

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

If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for 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 ☐ No ☐	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
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 ☐ No ☐	Yes ☐ No ☐

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. HOUSEHOLD DISCOUNT INFORMATION

You may be eligible for a policy with a lower rate based on your answers to the statements in this section.	**Applicant**	**Applicant B**
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.	Yes ☐ No ☐	Yes ☐ No ☐

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 ☐ No ☐	

Relationship to Applicant:

First Name

Last Name

Street Address

City State ZIP

Policy/Certificate Number

6. 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 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).

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)

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

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan _____

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.*

Line	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	**Rate Adjustment** *If you're in your open enrollment or guarantee issue period, skip to step #4.* On page 2, locate your height, then weight. If your weight is in the Standard column, enter the amount from line #2. If your weight is in the Class I or II column, multiply the amount on line #2 by: 1.10 if in 10% column 1.20 if in 20% column	$119.52 x 1.20 = $143.42 Person's weight is in the Class II 20% column.		
#4	**Payment Options** Your monthly payment is your last premium entered (line #2 or #3). 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)	$143.42 monthly payment $430.26 quarterly payment $860.52 semiannual payment $1,721.04 annual payment		

Complete and return with application

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.

Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	‹ 54	54 – 60	61 – 110	111 – 128	129 – 145	146 +
4' 3''	‹ 56	56 – 62	63 – 114	115 – 133	134 – 151	152 +
4' 4''	‹ 58	58 – 65	66 – 119	120 – 138	139 – 157	158 +
4' 5''	‹ 60	60 – 67	68 – 123	124 – 143	144 – 163	164 +
4' 6''	‹ 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7''	‹ 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8''	‹ 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9''	‹ 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4' 10''	‹ 72	72 – 81	82 – 148	149 – 172	173 – 196	197 +
4' 11''	‹ 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0''	‹ 77	77 – 87	88 – 158	159 – 184	185 – 209	210 +
5' 1''	‹ 80	80 – 89	90 – 164	165 – 190	191 – 216	217 +
5' 2''	‹ 83	83 – 92	93 – 169	170 – 196	197 – 224	225 +
5' 3''	‹ 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5' 4''	‹ 88	88 – 99	100 – 180	181 – 209	210 – 238	239 +
5' 5''	‹ 91	91 – 102	103 – 186	187 – 216	217 – 246	247 +
5' 6''	‹ 93	93 – 105	106 – 192	193 – 223	224 – 254	255 +
5' 7''	‹ 96	96 – 108	109 – 197	198 – 229	230 – 261	262 +
5' 8''	‹ 99	99 – 111	112 – 203	204 – 236	237 – 269	270 +
5' 9''	‹ 102	102 – 115	116 – 209	210 – 243	244 – 277	278 +
5' 10''	‹ 105	105 – 118	119 – 216	217 – 250	251 – 285	286 +
5' 11''	‹ 108	108 – 121	122 – 222	223 – 258	259 – 293	294 +
6' 0''	‹ 111	111 – 125	126 – 228	229 – 265	266 – 302	303 +
6' 1''	‹ 114	114 – 128	129 – 234	235 – 272	273 – 310	311 +
6' 2''	‹ 117	117 – 132	133 – 241	242 – 280	281 – 319	320 +
6' 3''	‹ 121	121 – 136	137 – 248	249 – 288	289 – 328	329 +
6' 4''	‹ 124	124 – 139	140 – 254	255 – 295	296 – 336	337 +
6' 5''	‹ 127	127 – 143	144 – 261	262 – 303	304 – 345	346 +
6' 6''	‹ 130	130 – 147	148 – 268	269 – 311	312 – 354	355 +
6' 7''	‹ 134	134 – 150	151 – 275	276 – 319	320 – 363	364 +
6' 8''	‹ 137	137 – 154	155 – 282	283 – 327	328 – 373	374 +
6' 9''	‹ 140	140 – 158	159 – 289	290 – 335	336 – 382	383 +
6' 10''	‹ 144	144 – 162	163 – 296	297 – 344	345 – 392	393 +
6' 11''	‹ 147	147 – 166	167 – 303	304 – 352	353 – 401	402 +
7' 0''	‹ 151	151 – 170	171 – 311	312 – 361	362 – 411	412 +
7' 1''	‹ 155	155 – 174	175 – 318	319 – 369	370 – 421	422 +
7' 2''	‹ 158	158 – 178	179 – 326	327 – 378	379 – 431	432 +
7' 3''	‹ 162	162 – 183	184 – 333	334 – 387	388 – 441	442 +
7' 4''	‹ 166	166 – 187	188 – 341	342 – 396	397 – 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, UM2, UM3, UM4, UM5, UM6, UM7, UM8, UM9 or state equivalent.

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.

United of Omaha Life Insurance Company

Please refer to instructions on the back of this form.

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.

Medicare Supplement Premium Payment Options:	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
a. Pay all premiums (1st month and monthly renewals) by ACH/BSP	☐	☐	☐	☐
b. Pay 1st premium by paper check and pay monthly renewals by BSP	☐	☐	☐	☐
c. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)**	☐	☐	☐	☐
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	$_____		$_____	
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?	☐	☐	☐	☐
If yes, is the applicant:				
(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) are "Yes," premiums CAN be paid with a business account				

Applicant A

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 B

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)
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.

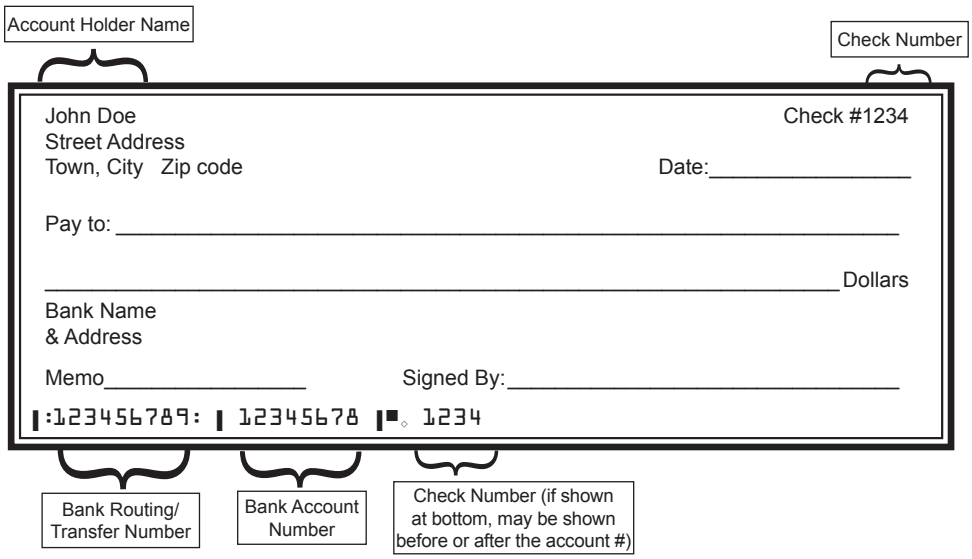
Payments can not be postponed until a later date.

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.



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

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 B

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

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

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

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

"Specified Companies" means:

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

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to United of Omaha Life Insurance Company.

Purposes

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.

Potential for Redisclosure

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

Failure to Sign

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

Expiration and Revocation

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

ATTN: Individual Underwriting
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 United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

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

Names and Signatures

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

_____

Applicant	**Applicant B**
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.

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**
_____ 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	My plan has outpatient prescription drug coverage
_____ coverage and I am enrolling in Part D	_____ and I am enrolling in Part D
Disenrollment from a Medicare Advantage Plan	Disenrollment from a Medicare Advantage Plan
_____ Please explain reason for disenrollment	_____ 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 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 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.

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**
_____ 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	_____ Disenrollment from a Medicare Advantage Plan
_____ Please explain reason for disenrollment	_____ 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 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 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

Please refer to instructions on the back of this form.

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.

Medicare Supplement Premium Payment Options:	**Applicant A** YES	**Applicant A** NO	**Applicant B** YES	**Applicant B** NO
a. Pay all premiums (1st month and monthly renewals) by ACH/BSP	☐	☐	☐	☐
b. Pay 1st premium by paper check and pay monthly renewals by BSP	☐	☐	☐	☐
c. Pay initial premium by ACH and pay renewals by direct bill **(monthly direct billing is not offered)**	☐	☐	☐	☐
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	$_____		$_____	
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?	☐	☐	☐	☐
If yes, is the applicant:				
(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) are "Yes," premiums CAN be paid with a business account				

Applicant A

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 B

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)
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.

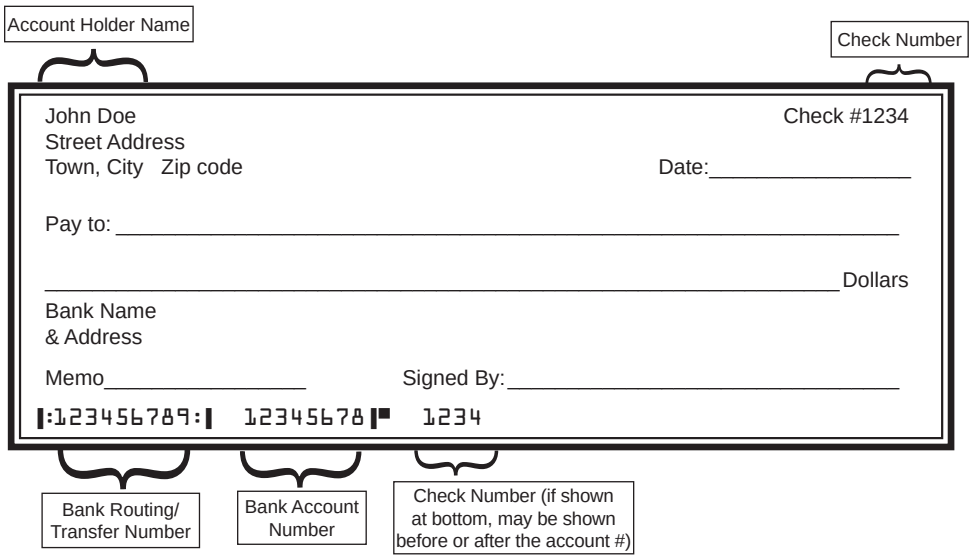
Payments can not be postponed until a later date.

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.



UNITED OF OMAHA LIFE INSURANCE COMPANY
A Mutual of Omaha Company
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
BENEFIT PLANS A, F AND G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

Basic Benefits for Plans A through L:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services
Blood: First 3 pints of blood each year

	A	B	C	D	E	**F**	F*	**G**	H	I	J	J*	K**	L**
Basic Benefits	**X**	X	X	X	X	**X**		**X**	X	X	X		X	X
Skilled Nursing Facility Coinsurance			X	X	X	**X**		**X**	X	X	X		50%	75%
Part A Deductible		X	X	X	X	**X**		**X**	X	X	X		50%	75%
Part B Deductible			X			**X**					X			
Part B Excess						**100%**		**80%**		100%	100%			
Foreign Travel Emergency			X	X	X	**X**		**X**	X	X	X			
At-Home Recovery				X				**X**		X	X			
Preventive Care NOT Covered By Medicare					X						X			
Out-of-Pocket Annual Limit													$4,440***	$2,220***

* Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plan F and J after one has paid a calendar year $1,900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost-sharing for items and services than Plans A through J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 290-293 and 296-297

NON-TOBACCO

FEMALE				MALE		
Plan A UM1	**Plan F UM4**	**Plan G UM5**	**Attained Age**	**Plan A UM1**	**Plan F UM4**	**Plan G UM5**
$59.93	$86.86	$71.22	**65**	$63.08	$91.43	$74.97
$59.93	$86.86	$71.22	**66**	$63.08	$91.43	$74.97
$62.27	$90.25	$74.00	**67**	$66.25	$96.01	$78.73
$64.71	$93.78	$76.90	**68**	$69.58	$100.84	$82.69
$67.24	$97.44	$79.90	**69**	$73.08	$105.92	$86.85
$69.73	$101.06	$82.87	**70**	$76.63	$111.06	$91.07
$72.19	$104.62	$85.79	**71**	$80.20	$116.24	$95.32
$74.69	$108.24	$88.75	**72**	$83.91	$121.62	$99.72
$77.19	$111.86	$91.73	**73**	$87.71	$127.12	$104.23
$79.68	$115.48	$94.70	**74**	$91.59	$132.74	$108.85
$82.02	$118.87	$97.47	**75**	$95.37	$138.22	$113.34
$84.01	$121.75	$99.84	**76**	$98.83	$143.24	$117.46
$85.47	$123.87	$101.58	**77**	$100.56	$145.73	$119.50
$86.93	$125.98	$103.31	**78**	$102.27	$148.21	$121.53
$88.51	$128.27	$105.19	**79**	$104.13	$150.91	$123.75
$90.03	$130.49	$107.00	**80**	$105.92	$153.51	$125.88
$92.01	$133.35	$109.35	**81**	$107.00	$155.07	$127.15
$93.94	$136.14	$111.63	**82**	$107.97	$156.47	$128.31
$95.78	$138.82	$113.83	**83**	$108.84	$157.75	$129.35
$97.57	$141.41	$115.96	**84**	$109.63	$158.89	$130.29
$99.28	$143.88	$117.98	**85**	$110.31	$159.87	$131.09
$100.91	$146.25	$119.92	**86**	$110.89	$160.72	$131.79
$102.47	$148.50	$121.77	**87**	$111.37	$161.41	$132.36
$103.93	$150.62	$123.51	**88**	$111.75	$161.96	$132.80
$105.29	$152.60	$125.13	**89**	$112.01	$162.34	$133.12
$106.54	$154.40	$126.61	**90 and Over**	$112.14	$162.53	$133.27

See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 290-293 and 296-297

TOBACCO

FEMALE				MALE		
Plan A UM1	**Plan F UM4**	**Plan G UM5**	**Attained Age**	**Plan A UM1**	**Plan F UM4**	**Plan G UM5**
$68.89	$99.84	$81.86	**65**	$72.51	$105.09	$86.18
$68.89	$99.84	$81.86	**66**	$72.51	$105.09	$86.18
$71.58	$103.73	$85.06	**67**	$76.15	$110.35	$90.49
$74.38	$107.80	$88.39	**68**	$79.98	$115.91	$95.05
$77.29	$112.00	$91.84	**69**	$84.00	$121.75	$99.83
$80.15	$116.17	$95.26	**70**	$88.09	$127.66	$104.68
$82.97	$120.25	$98.60	**71**	$92.19	$133.61	$109.56
$85.85	$124.41	$102.02	**72**	$96.45	$139.79	$114.62
$88.72	$128.58	$105.44	**73**	$100.81	$146.11	$119.81
$91.59	$132.74	$108.85	**74**	$105.28	$152.58	$125.11
$94.27	$136.63	$112.03	**75**	$109.62	$158.87	$130.27
$96.57	$139.95	$114.75	**76**	$113.60	$164.64	$135.01
$98.24	$142.38	$116.76	**77**	$115.58	$167.51	$137.35
$99.91	$144.81	$118.74	**78**	$117.55	$170.36	$139.69
$101.74	$147.44	$120.90	**79**	$119.69	$173.46	$142.24
$103.49	$149.98	$122.98	**80**	$121.75	$176.45	$144.69
$105.76	$153.28	$125.69	**81**	$122.98	$178.24	$146.15
$107.97	$156.48	$128.31	**82**	$124.10	$179.86	$147.49
$110.10	$159.56	$130.84	**83**	$125.11	$181.32	$148.68
$112.15	$162.54	$133.29	**84**	$126.01	$182.63	$149.75
$114.11	$165.38	$135.61	**85**	$126.79	$183.76	$150.68
$115.99	$168.11	$137.84	**86**	$127.46	$184.73	$151.48
$117.78	$170.69	$139.97	**87**	$128.02	$185.53	$152.14
$119.46	$173.12	$141.96	**88**	$128.45	$186.16	$152.65
$121.03	$175.40	$143.83	**89**	$128.75	$186.60	$153.01
$122.46	$177.47	$145.53	**90 and Over**	$128.90	$186.81	$153.19

See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 294-295 and 298-299

NON-TOBACCO

FEMALE				MALE		
Plan A UM1	**Plan F UM4**	**Plan G UM5**	**Attained Age**	**Plan A UM1**	**Plan F UM4**	**Plan G UM5**
$65.76	$95.30	$78.15	**65**	$69.22	$100.32	$82.26
$65.76	$95.30	$78.15	**66**	$69.22	$100.32	$82.26
$68.33	$99.02	$81.20	**67**	$72.69	$105.34	$86.38
$71.01	$102.90	$84.38	**68**	$76.35	$110.65	$90.73
$73.77	$106.92	$87.67	**69**	$80.19	$116.22	$95.29
$76.51	$110.89	$90.93	**70**	$84.08	$121.86	$99.93
$79.21	$114.79	$94.13	**71**	$88.00	$127.54	$104.59
$81.95	$118.76	$97.38	**72**	$92.07	$133.44	$109.42
$84.69	$122.74	$100.65	**73**	$96.24	$139.47	$114.37
$87.43	$126.71	$103.91	**74**	$100.50	$145.65	$119.43
$89.99	$130.42	$106.94	**75**	$104.64	$151.65	$124.35
$92.18	$133.59	$109.54	**76**	$108.44	$157.17	$128.88
$93.78	$135.91	$111.45	**77**	$110.33	$159.90	$131.12
$95.38	$138.23	$113.35	**78**	$112.21	$162.62	$133.35
$97.12	$140.75	$115.41	**79**	$114.25	$165.58	$135.78
$98.79	$143.17	$117.40	**80**	$116.22	$168.44	$138.12
$100.96	$146.32	$119.98	**81**	$117.40	$170.14	$139.52
$103.07	$149.37	$122.48	**82**	$118.46	$171.69	$140.79
$105.10	$152.31	$124.90	**83**	$119.43	$173.08	$141.93
$107.06	$155.16	$127.23	**84**	$120.29	$174.33	$142.95
$108.93	$157.87	$129.45	**85**	$121.03	$175.41	$143.84
$110.72	$160.47	$131.58	**86**	$121.67	$176.34	$144.60
$112.43	$162.94	$133.61	**87**	$122.20	$177.10	$145.23
$114.03	$165.26	$135.52	**88**	$122.61	$177.70	$145.71
$115.53	$167.43	$137.30	**89**	$122.90	$178.12	$146.06
$116.90	$169.41	$138.92	**90 and Over**	$123.05	$178.33	$146.23

See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

UNITED OF OMAHA LIFE INSURANCE COMPANY

MONTHLY RATES*

ZIP CODES: 294-295 and 298-299

TOBACCO

FEMALE				MALE		
Plan A UM1	**Plan F UM4**	**Plan G UM5**	**Attained Age**	**Plan A UM1**	**Plan F UM4**	**Plan G UM5**
$75.59	$109.54	$89.82	**65**	$79.56	$115.31	$94.56
$75.59	$109.54	$89.82	**66**	$79.56	$115.31	$94.56
$78.53	$113.82	$93.33	**67**	$83.55	$121.08	$99.29
$81.62	$118.28	$96.99	**68**	$87.75	$127.18	$104.29
$84.80	$122.89	$100.77	**69**	$92.17	$133.58	$109.53
$87.94	$127.46	$104.52	**70**	$96.65	$140.07	$114.86
$91.04	$131.94	$108.19	**71**	$101.15	$146.60	$120.21
$94.19	$136.50	$111.94	**72**	$105.83	$153.38	$125.77
$97.34	$141.08	$115.69	**73**	$110.62	$160.32	$131.46
$100.50	$145.64	$119.43	**74**	$115.51	$167.41	$137.28
$103.44	$149.91	$122.92	**75**	$120.28	$174.31	$142.94
$105.96	$153.55	$125.91	**76**	$124.65	$180.65	$148.13
$107.80	$156.22	$128.11	**77**	$126.82	$183.79	$150.71
$109.63	$158.89	$130.29	**78**	$128.98	$186.92	$153.28
$111.63	$161.78	$132.66	**79**	$131.32	$190.33	$156.06
$113.55	$164.57	$134.94	**80**	$133.59	$193.61	$158.76
$116.04	$168.18	$137.91	**81**	$134.94	$195.56	$160.36
$118.47	$171.69	$140.79	**82**	$136.16	$197.34	$161.82
$120.80	$175.07	$143.56	**83**	$137.27	$198.95	$163.14
$123.06	$178.34	$146.25	**84**	$138.27	$200.38	$164.31
$125.21	$181.46	$148.80	**85**	$139.12	$201.62	$165.33
$127.27	$184.45	$151.25	**86**	$139.85	$202.69	$166.21
$129.23	$187.29	$153.58	**87**	$140.46	$203.57	$166.93
$131.07	$189.96	$155.76	**88**	$140.94	$204.25	$167.49
$132.79	$192.45	$157.81	**89**	$141.27	$204.74	$167.88
$134.36	$194.73	$159.68	**90 and Over**	$141.43	$204.97	$168.08

See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

PREMIUM INFORMATION

We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 90, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the Policy Date. Schedules of rates may vary depending upon your Policy Date.

Risk Class Rating: If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I - 10% or Class II - 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

Household Premium Discount: If you have resided with at least one, but no more than three, other Medicare eligible adults for the past year, or you are married, and at least one of these other adults or your spouse also owns or is issued a Medicare supplement policy underwritten by United of Omaha or its affiliates, you will be eligible for a household premium discount. The discounted premium will be priced 7% lower than the rates illustrated. Your policy's household premium discount will be removed if your spouse or the other Medicare supplement policyholder chooses to terminate their Medicare supplement policy or he or she no longer resides with you (other than in the case of their death).

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not fully cover all of your medical costs. Neither United of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,024	$0	$1,024 (Part A Deductible)
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
● While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
● Once lifetime reserve days are used:		100% of Medicare	
● Additional 365 days	$0	Eligible Expenses	$0**
● Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $128 a day	$0	Up to $128 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits."

During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B Deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0

PLANS F and G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,024	$1,024 (Part A Deductible)	$0	$1,024 (Part A Deductible)	$0
61st through 90th day	All but $256 a day	$256 a day	$0	$256 a day	$0
91st day and after: •While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0	$512 a day	$0
•Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**	100% of Medicare Eligible Expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0	$0	$0
21st through 100th day	All but $128 a day	Up to $128 a day	$0	Up to $128 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLANS F AND G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	100%	$0	80%	20%
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0	$0	$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE-MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment • First $135 of Medicare Approved Amounts*	$0	$135 (Part B Deductible)	$0	$0	$135 (Part B Deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0	20%	$0

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOME HEALTH CARE–AT HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan ● Benefit for each visit	$0	N/A	All costs	Actual charges to $40 a visit	Balance
● Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	N/A	All costs	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
● Calendar year maximum	$0	N/A	All costs	$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250	$0	$250
Remainder of charges	$0	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime Maximum Benefit