Manager/Commission Code (Required Field for Brokerage)	

Mutual of Omaha Insurance Company

Application for Individual Disability Income Insurance

SECTION A PROPOSED INSURED INFORMATION

Proposed Insured's Name (First, Middle, Last)	☐ Male ☐ Female	Birth Date	Birth State
Primary Residence Address (Number, Street, City, State, Zip)	Social Security Number	Telephone Number ( ) _____ - _____	
Mailing Address for Premium Notices (if different than above)	Email		
Full Name of Beneficiary	Relationship to Proposed Insured		

Plan Information

Monthly Benefit Amount $ _____ ($300 - $4,000) Must select benefit in increments of $100

Accident/Sickness Elimination Period: ☑ 30/90 Days

Maximum Benefit Period: ☐ 12 Months ☐ 24 Months ☐ 36 Months

Occupational/Financial Information

1. Occupation _____
2. Annual Earned Income? If self-employed, taxable (net) income $ _____
3. For the last 6 months, have you been continuously at work for at least 30 hours per week with your current employer performing all the duties of your occupation? ☐ Yes ☐ No
4. For the last 6 months, have you worked entirely in an office (administrative) setting? ☐ Yes ☐ No
5. Are you currently in the process of filing or had a bankruptcy discharge in the last 2 years? ☐ Yes ☐ No
6. Do you have other disability coverage that will remain in force, which when combined with this applied for coverage, will exceed 70 percent of your annual earned income? ☐ Yes ☐ No

Replacement Information

Is the coverage applied for replacing any existing coverage for the Proposed Insured? ☐ Yes ☐ No
If "Yes," please give details below.

Company	Policy Number	Monthly Benefit Amount

SECTION B UNDERWRITING INFORMATION

1. Are you a U.S. Citizen or a Permanent Resident Card holder who has resided in the U.S. for 3 or more years? ☐ Yes ☐ No
2. During the last 12 months, have you used any form of tobacco or any form of nicotine replacement/cessation product (such as nicotine gum, patch, spray, ecig. and vapor)? ☐ Yes ☐ No
3. Height (Ft) _____ (In) _____ Weight (Lbs) _____.

If the Proposed Insured answers "Yes" to any of the following questions, that person will not be eligible for any coverage under this application.

4. Are you pregnant? ☐ Yes ☐ No
5. During the last 12 months, other than for childbirth, have you:
   a. Been admitted to a hospital? ☐ Yes ☐ No
   b. Had surgery, received, or been advised by a member of the medical profession to receive physical or occupational therapy? ☐ Yes ☐ No
   c. Had 2 or more blood pressure readings over 140/90 taken by a member of the medical profession? ☐ Yes ☐ No
6. During the last 2 years, have you been advised by a medical professional to undergo treatment, surgery, procedure, diagnostic evaluation or testing that has not yet been completed or diagnostic tests performed where the results are still pending or were inconclusive? ☐ Yes ☐ No
7. During the last 2 years, have you used marijuana in any form for recreational or medical purposes? ☐ Yes ☐ No
8. During the last 5 years, have you used narcotics in any form for recreational or medical purposes, cocaine, hallucinogens, barbiturates or other drugs? ☐ Yes ☐ No

9. During the last 5 years, have you been declined for any disability or life insurance policy? ☐ Yes ☐ No
10. During the last 5 years, have you applied for or received disability benefits? ☐ Yes ☐ No
11. During the last 5 years, have you plead guilty to or been convicted of a felony, driving under the influence of alcohol or drugs, been incarcerated or currently on probation or parole? ☐ Yes ☐ No
12. During the last 5 years, have you been treated for alcohol use? ☐ Yes ☐ No
13. During the last 5 years, have you been diagnosed with or treated for Human Immunodeficiency Syndrome (HIV)/Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
14. During the last 5 years, have you been diagnosed with, received care or treatment, or been advised by a member of the medical profession to seek treatment for or consulted with a health care provider regarding:
    a. Manic Depressive Illness (Bipolar), schizophrenia, Post Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No
    b. Brain or nerve system disease or disorder, including but not limited to, epilepsy, concussion syndrome (Traumatic Brain Injury), Dementia, Alzheimers, Multiple Sclerosis, Parkinson's, Amyotrophic Lateral Sclerosis (ALS), neuropathy or stroke? ☐ Yes ☐ No
    c. Heart or artery disease, disorder or surgery? ☐ Yes ☐ No
    d. Lung disease or disorder, including but not limited to, chronic bronchitis, emphysema or severe sleep apnea? ☐ Yes ☐ No
    e. Leukemia, lymphoma, melanoma (except basal cell skin cancer) or any other cancer? ☐ Yes ☐ No
    f. Musculoskeletal disease or disorder, including but not limited to, fibromyalgia, chronic fatigue, rheumatoid or psoriatic arthritis? ☐ Yes ☐ No
    g. Treatment or surgery of the spine, neck, back, hip, knee or shoulder? ☐ Yes ☐ No
    h. Inflammatory bowel disease, including but not limited to, Crohn's or ulcerative colitis? ☐ Yes ☐ No
    i. Chronic kidney disease? ☐ Yes ☐ No
    j. Liver disease, including but not limited to, cirrhosis, hepatitis B or C? ☐ Yes ☐ No
    k. Organ transplant? ☐ Yes ☐ No
    l. Diabetes? ☐ Yes ☐ No
    m. Connective tissue disease or disorder including, but not limited to, Systemic Lupus Erythematosus (SLE), scleroderma or polymyositis? ☐ Yes ☐ No
    n. Blood disease or disorder, including but not limited to, sickle cell anemia or blood clotting disorder? ☐ Yes ☐ No

SECTION C PLEASE READ AND SIGN

AGREEMENTS AND ACKNOWLEDGEMENTS

To the best of your knowledge and belief, you represent that your answers are true and complete. Incorrect or misleading answers may void this application and policy from its effective date. Mutual of Omaha Insurance Company ("Mutual of Omaha") may require additional information for underwriting. Mutual of Omaha will not issue a policy unless it receives all of the underwriting information requested and determined that you are eligible for the exact insurance applied for as of the application date or you have accepted an offer by us for coverage other than for which you applied. If your policy is issued as you applied for it, the issued policy will indicate its effective date. This application does not provide temporary insurance. If this application is declined, any advance premium payment submitted with the application will be refunded without interest. No insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first Modal premium is received by Mutual of Omaha during your lifetime. No producer can waive or change any receipt or policy provision or agree to issue any policy.

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

I have (a) read and understand the Agreements and Acknowledgements and Fraud Warning Sections; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: _____ _____
City State Date

_____ _____ _____
Signature of Proposed Insured Printed Name of Proposed Insured Date

Producer Section:

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . . . ☐ Yes ☐ No

(If "No," please explain.)_____

_____ _____ _____ _____ _____
Signature of Producer Producer's Printed Name Producer Email Producer # Date

_____ _____
Office Name Office Address

_____ _____ _____ _____ _____
Signature of Producer Producer's Printed Name Producer Email Producer # Date

_____ _____
Office Name Office Address

Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza, Omaha, NE 68175, 800-775-6000

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

Payment Information

Premium Quoted $_____

1. **First Premium Payment** (check one)

☐ Automated Bank Account Withdrawal

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AT POLICY 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 issued, 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/Insured will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

☐ Check Submitted With Application Amount of Check $_____

2. **Ongoing Premium Payments** (check one)

☐ Automated Bank Account Withdrawal (Monthly)

☐ 1st of the Month
or
☐ 15th of the Month

Ongoing premiums are due and will be automatically withdrawn from the account below on the date selected above. **Ongoing withdrawals will begin once the policy is issued.**

☐ Direct Bill (check one)

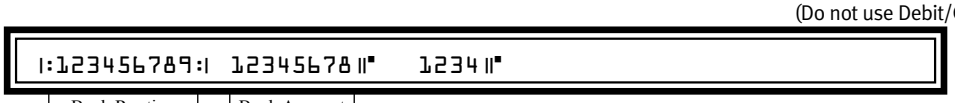
☐ Annual
☐ Semiannual
☐ Quarterly

Account Information

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)



Name of payor as shown on bank account: _____ Social Security No. _____

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

☐ Employer
☐ Business owned by Proposed Insured/Insured or Spouse
☐ Power of Attorney or legal guardian
☐ Living Trust
☐ Spouse
☐ Other _____

Authorization

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 Mutual of Omaha in writing of any changes in my account information. This authorization will be effective until Mutual of Omaha gives 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.

Date _____ X _____

Mo./Day/Yr. Authorized Signature as Shown on Account

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

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

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

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

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that if the person or entity to whom Personal information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal information may be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

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

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

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

_____

_____ **Date:** _____
Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) Mo Day Yr

_____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) Mo Day Yr

_____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors 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, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

_____
Applicant's Signature

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

Mutual of Omaha Insurance Company – Notice of Information Practices

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

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

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

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

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

M26977

GIVE THIS NOTICE TO THE APPLICANT

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

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

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

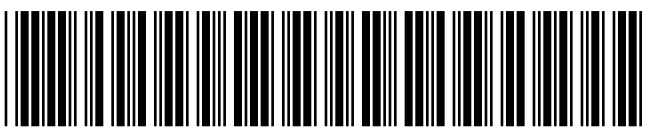
1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

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, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

_____
Applicant's Signature



MUTUAL OF OMAHA INSURANCE COMPANY

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

SHORT-TERM DISABILITY INCOME INSURANCE

OUTLINE OF COVERAGE
ICC15DT2

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!

Disability Income Insurance Coverage – Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or *sickness* which is not sustained while you working at any job for pay or benefits, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits – If you are *totally disabled* because of a *sickness* or *injury*, we will pay the *total disability monthly benefit*. *Total disability* benefits begin after the *elimination period* has been satisfied. Benefits are payable while you remain *totally disabled* for as long as the *maximum benefit period*.

Partial Disability Benefits – If you are *partially disabled* because of a *sickness* or *injury*, we will pay 50% of the *total disability monthly benefit*. *Partial disability* benefits begin after the *elimination period* has been satisfied. Benefits are payable while you remain *partially disabled* for the lesser of six months or the balance of the *maximum benefit period*.

Recurrent Disability – A new *elimination period* will apply to:

a) a later disability that results from the same cause or causes as a prior disability if you were able to return to *full-time employment* between such disabilities for at least six months in a row; and

b) a later disability that results from a different cause or causes as a prior disability if you were able to return to *full-time employment* between such disabilities for at least 30 calendar days in a row.

Concurrent Disability – If you are *totally disabled* or *partially disabled* as a result of more than one *injury* and/or *sickness* at the same time, benefits will be considered the same as if the disability resulted from only one cause. In no event will you be considered to have more than one *total disability* or *partial disability* at one time.

Rehabilitation Benefit – While you are receiving *total disability* or *partial disability* benefits, we may pay for a vocational rehabilitation program.

Exclusions and Limitations

Your policy pays benefits only for loss or disability that is not sustained while you are working at any job for pay or benefits. We will not pay benefits for:

a) loss that begins while this policy is not in force;
b) loss resulting from an act of declared or undeclared war;
c) loss sustained as a result of serving in active duty in the armed forces (coverage may be suspended as described in the **Military Suspension** provision of your policy);
d) loss caused by attempted suicide or intentionally self-inflicted *injury*;
e) loss resulting from commission or attempted commission of a felony;
f) loss resulting from your being legally intoxicated as defined by state law where the loss occurs, or loss that results from the use of narcotics or other controlled substances (except for narcotics given on the advice of and taken as prescribed by a *physician*);
g) loss resulting from *substance abuse*;
h) loss resulting from *mental or nervous disorders*, regardless of cause;
i) loss resulting from cosmetic surgery (except reconstructive surgery when the surgery is incidental to or surgery following trauma, infection, or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly resulting in a functional defect);
j) loss resulting from engagement in an illegal occupation; or
k) loss that results during a period of incarceration in a penal or correctional institution of more than seven days.

Pregnancy Limitation – Benefits are not payable for *normal pregnancy* or normal childbirth until you have been disabled for 90 days. We will pay benefits for loss resulting from *complications of pregnancy* on the same basis as any other *sickness*.

Pre-existing Condition Limitation - We will not pay benefits for loss resulting from a *pre-existing condition*, unless such loss occurs two years or more after the *policy date*.

Guaranteed Renewable to Age 65 – You are guaranteed the right to continue your coverage until *age* 65 as long as your *maximum benefit period* has not been exhausted. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

Your Premium Can Change – Your policy's premium may change, but only if the same change is made to all policies of this form issued to persons of the same *class*. We will give you at least 45 days' advance written notice before any premium change. In no event will the premium increase during the first 12 months following the *policy date*.

Misstatement of Age – If you misstated your age, we will adjust all benefits payable to those which the premium paid would have purchased at the correct age. If coverage would not have been available at your correct age, we will refund any unearned premiums paid and your policy will terminate.