APPLICATION TO
MUTUAL OF OMAHA INSURANCE COMPANY/UNITED OF OMAHA LIFE INSURANCE COMPANY
FOR GROUP INSURANCE

1. UNDERWRITING COMPANY (Check Appropriate Box Below):

☐ MUTUAL OF OMAHA INSURANCE COMPANY
☐ UNITED OF OMAHA LIFE INSURANCE COMPANY

located at Mutual of Omaha Plaza, Omaha, NE 68175

For Home Office Use Only	
POLICY NUMBER(S) ASSIGNED	
____________	____________
____________	____________
____________	____________

2. APPLICANT (Full Legal Name) ______________________________

____

STREET ADDRESS ______________________________

CITY ______________ **STATE** __________ **ZIP CODE** __________

TELEPHONE NUMBER (________) ______ - ______

3. MEDICAL INFORMATION

In the space provided on the next page, list all eligible employees, retirees and dependents to whom on the earlier of:

(a) the requested effective date of this policy(ies); or
(b) the date this application is signed,

any of the following conditions apply and who are to be covered under the policy(ies).

1. An employee who is not actively at work at his or her regular workplace because of an injury or illness.
2. A dependent or retired employee who:
   a. is disabled, either physically or mentally to the extent of being unable to perform all of the usual and customary activities (the "normal activities") of a person of the same age or sex who is in good health; or
   b. is covered by your existing group plan as an incapacitated or handicapped child (i.e., a child who would not be eligible for coverage but for the existence of a physical or mental handicap which makes the child incapable of self-sustaining employment).
3. An employee, dependent or retiree who:
   a. is confined to a hospital, or any other institution or facility other than a hospital or at home or else where due to any injury or illness.
   b. has incurred medical expenses in excess of $25,000 during the past 24 months; or
   c. has a chronic or serious medical condition (including but not limited to cancer, heart disease, alzheimers disease, mental illness, substance abuse).

NOTE: Any employee, retiree or dependent named on the next page will become insured as described in the policy(ies).

If the plan applied for is a Health and Welfare Fund that utilizes an Hour Bank eligibility, list only those persons for whom there is no active eligibility through an accrued Hour Bank balance or those who have continued coverage through a specific Disability continuation provision.

Name of Individual (please check if employee (E), dependent (D) or retiree (R))				Date of Birth MM/DD/YY	Date Disability or Confinement Began MM/DD/YY	Nature of Disability or Confinement
	E ☐	D ☐	R ☐	/ /	/ /	
	E ☐	D ☐	R ☐	/ /	/ /	
	E ☐	D ☐	R ☐	/ /	/ /	
	E ☐	D ☐	R ☐	/ /	/ /	
	E ☐	D ☐	R ☐	/ /	/ /	
	E ☐	D ☐	R ☐	/ /	/ /	

(Any Additional Names and Information should be attached on a separate page.)

4. CONTINUATION OF COVERAGE INFORMATION (Complete for medical, dental, prescription drug and vision benefits.)

List below the requested detail, for <u>**ALL**</u> employees or dependents whose coverage is to be continued under the Consolidated Omnibus Reconciliation Act of 1985 **(COBRA)**, State mandated or any other continuation of benefits and are to be insured under the policy(ies).

Name of Individual Social Security No.	Original Starting Date of Continued Coverage	Check mark applicable boxes below.				
		*Termination	Death	Divorce	Other	(If Other, please explain)
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

(Photo this page for additional Names and Information)

*If termination is due to a disability, those individuals must also be listed in 3 above.

5. **THE FOLLOWING IS UNDERSTOOD AND AGREED UPON (UNLESS SPECIFIED IN 7 BELOW.)**

(a) An eligible employee who is to be insured under the policy(ies) must be working 30 hours or more a week at his or her regular work place, or other location to which the employee must travel to perform his or her regular job duties. Such employees will become insured as described in the policy(ies.)

(b) A retiree or dependent who is to be insured under the policy(ies) and who is:
1. hospital confined;
2. confined in any institution or facility other than a hospital or at home or elsewhere due to an injury or sickness; or
3. disabled, either physically or mentally, to the extent of being unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health;

will become insured as described in the policy(ies).

(c) Other eligibility requirements are described in the policy.

6. Certain states have enacted legislation which requires insurers to provide specific coverage for people residing in or working in their states. Do you have any eligible employees residing in or working in Arizona, California, Kansas, Florida, Hawaii, Idaho, Indiana, Maryland, Montana, South Carolina, South Dakota or Washington? ☐ Yes ☐ No

If Yes, indicate which state(s) ______________________________

7. Group Insurance is applied for as specified in the proposal dated ________ with the following modifications;

____

____

____

If no modifications are shown above, none will be presumed.

8. **FINANCIAL CONDITION**

Within the last 5 years, has the applicant remained continually solvent? ☐ Yes ☐ No

Does the applicant reasonably expect to be solvent within the next 12 months? ☐ Yes ☐ No

If no to either question, please give details. ______________________________

____

Solvent means not having filed a voluntary or involuntary petition in bankruptcy, a reorganization or an arrangement with creditors, or a general assignment for the benefit of creditors, the ability to pay debts as they become due, not having a trustee, receiver or other custodian appointed on its behalf, or any other case or proceeding under any bankruptcy or solvency law, or the commencement of any dissolution or liquidation proceeding.

Requested effective date of the policy(ies): ______________________________

This application is submitted with the following advance payment: $ ______________________________

I understand that the insurer will rely and act upon the answers, statements and any misstatements or omissions of information that are made on this Application or given and used in the preparation of the Proposal upon which this application is based. Erroneous information and any material omission of information can result in the rescission, cancellation or rerating of group insurance coverage issued in reliance thereon.

If this application is not approved by an officer at the Home Office of Underwriting Company, no insurance is in effect at any time and any advance payment received will be returned.

If this application is approved by an officer at the Home Office of Underwriting Company, it will be attached to and made a part of the policy. Unless notified in writing of an effective date other than the date shown above, the insurance will begin on the requested effective date of the policy.

Receipt of the policy and payment of any subsequent premium by the applicant will constitute acceptance of the policy.

For Applicant:

By ____

(Signature and Title)

Date ______________________________

NOTICE

THE INFORMATION ON THIS APPLICATION WILL NOT BE USED IN ANY MANNER THAT IS PROHIBITED BY HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) OR ANY APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS

MUTUAL OF OMAHA
PRIVACY NOTICE

Our Commitment to Privacy

The Mutual of Omaha family of companies is committed to carefully guarding the personal information you entrust to us. Our family of companies includes:

- Mutual of Omaha Insurance Company
- Mutual of Omaha Investor Services, Inc.
- Mutual of Omaha of South Dakota and Community Health Plus HMO, Inc.
- United of Omaha Life Insurance Company
- United World Life Insurance Company
- Companion Life Insurance Company
- Exclusive Healthcare, Inc.
- Omaha Property and Casualty Insurance Company

The statements in this notice apply to our current as well as former customers.

Your Health Information

The Mutual of Omaha family of companies does not share your health information, except as required or permitted by law.

Information We Collect

In the normal course of conducting business we may collect personal information about you, such as name, address, social security number, income, marital status, employment and similar personal information from:

- Information we receive from you on applications or other forms.
- Information about your transactions with our family of companies and other companies.
- Information from Mutual of Omaha websites (such as that provided through online forms, site visitor data and online information collecting devices known as "cookies").
- Information we request from other sources (such as motor vehicle reports, government agencies and medical information bureaus).
- Information we request from consumer-reporting agencies.

Information We Share

In the normal course of conducting business we may share your personal information among our family of companies. Depending on the products you have with us, the type of information we share could include your name, income, social security number and other identifying information you provide to us. We may also share information about your transactions with us, such as your payment history.

We do not share personal information with third parties outside our family of companies except as required or permitted by law.

How We Protect Your Information

We restrict access to your personal information to only the employees of the Mutual of Omaha family of companies and others who need to know the information to provide our insurance or financial services to you. We maintain physical, electronic and procedural safeguards in accordance with legal standards and established security standards and procedures to guard your personal information from unauthorized disclosure.