



Please return signed applications via one of the following methods:

EMAIL: [secure email link](#) (Ctrl+Click)
 tiffany@lowinsure.com

FAX: 1-541-284-2994

MAIL: CDA Insurance LLC
 P.O. Box 26540
 Eugene, OR 97402

OFFICE: CDA Insurance LLC
 2160 W 11th Ave Ste D
 Eugene, OR 97402

CONTACT: Tiffany Jackson, independent agent, with any questions or concerns, or if you prefer an electronic application.
 Email: tiffany@lowinsure.com or phone: 1-541-434-9613

DOCUMENTS: The 'Outline of Coverage' and Medicare's 'Choosing a Medigap' book are located under each company heading.

- www.medicare-oregon.com
- www.medicare-washington.com
- www.medicare-idaho.com
- www.medicare-texas.net

TPMO disclaimer: CDA Insurance LLC may not offer every plan available in your area. Currently represented in the Medicare Advantage market are all plans available from: 9 insurance companies in the state of Oregon, 9 in the state of Washington, 4 in the state of Idaho, and 3 in the state of Texas. Any information provided is limited to those plans we do offer in your area. For a breakdown by county, please visit our websites: [Oregon](#), [Washington](#), [Idaho](#), [Texas](#) Please contact Medicare.gov, 1-800-MEDICARE , or your local SHIP to obtain information on all of your options.



B. Applicant Information (Continued)

Applicant A

<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Social Security # <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>			
Height Ft <input type="text"/> In <input type="text"/>		Weight Lbs <input type="text"/>	
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N			

Applicant B

<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Social Security # <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/>			
Height Ft <input type="text"/> In <input type="text"/>		Weight Lbs <input type="text"/>	
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N			

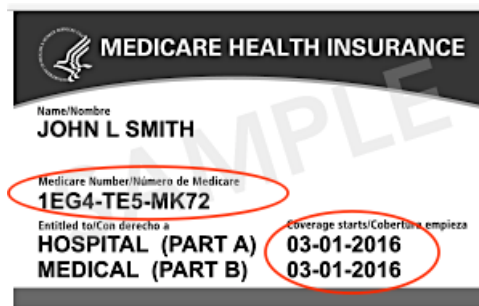
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific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

Receive statement online? ☐ Y ☐ N

Receive statement online? ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A

Medicare Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Applicant B

Medicare Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

NA6012-10 Rev 1021

D. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:

1. 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," answer the following about this existing coverage:

- (a) Will Medicaid pay your premiums for this Medicare supplement policy?.....
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....

Applicant A
☐ Y ☐ N

Applicant B
☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....

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

- (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

☐ Y ☐ N

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

Applicant B / / / / /

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

Applicant A

Name of Company

Plan

Applicant B

Name of Company

Plan

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

3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....

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

Applicant A
☐ Y ☐ N

Applicant B
☐ Y ☐ N

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

END / / / / /

Applicant B START / / / / /

END / / / / /

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....

☐ Y ☐ N

☐ Y ☐ N

- (c) Planned date of termination/disenrollment?..... Applicant A / / / / /

Applicant B / / / / /

- (d) Was this your first time in this type of Medicare plan?.....

☐ Y ☐ N

☐ Y ☐ N

- (e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....

☐ Y ☐ N

☐ Y ☐ N

- (f) Is your former Medicare supplement or Medicare Select policy certificate still available?

☐ Y ☐ N

☐ Y ☐ N

NA6012-10 Rev 1021





- (g) Please indicate reason for termination/disenrollment:
- Your Medicare Advantage plan is leaving the Medicare program.....
 - Your Medicare Advantage organization stopped offering Medicare Advantage plans.....
 - Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
 - You moved out of the geographic service area of your Medicare Advantage plan.....
 - You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....
 - Other: _____

Applicant A

Applicant B

Check box(s) below if applicable

Applicant A

☐
☐
☐
☐
☐

Applicant B

☐
☐
☐
☐
☐

Please answer questions regarding other health insurance:

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

Applicant A

☐ Y ☐ N

Applicant B

☐ Y ☐ N

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

- (a) What are your dates of coverage under the other policy/certificate?

If you are still covered under this plan, leave "END" blank..... Applicant A START

END

Applicant B START

END

- (b) Planned date of termination/disenrollment?..... Applicant A

Applicant B

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

- (d) Please state the reason for your disenrollment:

Applicant A

Applicant B

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

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

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

5. Are you applying during an open enrollment period?

- (a) Did you turn age 65 in the last six months?.....

- (b) Did you enroll in Medicare Part B in the last six months?.....

Applicant A

☐ Y ☐ N
☐ Y ☐ N

Applicant B

☐ Y ☐ N
☐ Y ☐ N

If either question 5a or 5b is "YES", indicate your Medicare Part B effective date

Applicant A

Applicant B

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

☐ Y ☐ N

☐ Y ☐ N



IF YOU ANSWER "YES" TO BOTH QUESTIONS 5A AND 5B OR QUESTION 6 IN SECTION E, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS F & G AND GO TO SECTION H.

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

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

F. Health Information

For all plans, answer questions 7-17. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 7-13, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Do you have or in the past five years, have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic lupus, scleroderma or myasthenia gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Within the past five years, have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Do you have Osteoporosis, and as a result, experienced a fracture?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Within the past five years have you been diagnosed with or treated for diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Part B: Medical Questions: (If "YES" is answered to any of the following questions 14-17 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

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



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

G. Medication Information

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

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
18. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

NA6012-10 Rev 1021



H. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services are through the Senior Health Insurance Benefit Advisors program (SHIBA) 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).



H. Agreement and Authorization (cont.)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO OMAHA INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes United of Omaha Life Insurance Company, Mutual of Omaha Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Omaha Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Omaha Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Omaha Insurance Company has taken action in reliance on the authorization or the law allows Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Omaha Insurance Company.

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

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

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



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

[illegible]

J. To be Completed by Producer

19. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).

(a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A

Applicant B

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

Applicant A

Applicant B

I/We certify as follows:

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

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

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

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



Signature of Licensed Producer

Date _____



Signature of Licensed Producer

Date _____

Printed Name _____

Printed Name

0	5	2	3	1	0	3
---	---	---	---	---	---	---

Agent Writing Number


Agent Writing Number



METHOD OF PAYMENT FORM

REQUIRED FORM - PLEASE RETURN PAGES 1 & 2

Part I. Select Premium Payment Option

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

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

Each month, payments will be automatically deducted from the account below on the day selected above. **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

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



Part III. Account Information

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

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings
Name of Financial Institution

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

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

Name as Shown on Account

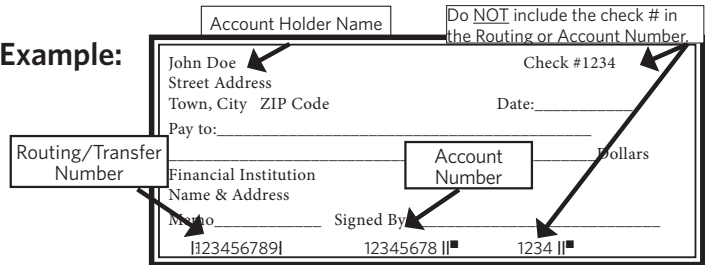
Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings
Name of Financial Institution

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

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

Name as Shown on Account

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



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

Applicant A

Authorized Signature as Shown on Account

Date

Applicant B

Authorized Signature as Shown on Account

Date



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

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy or certificate until you have received your new policy and are sure that you want to keep it.

X
Signature of Agent, Broker or Other Representative* Date
OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

OMAHA INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

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X

Signature of Agent, Broker or Other Representative*

Date

OMAHA INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.