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

LUMP SUM PORTFOLIO
NEW BEGINNINGS
- CANCER
- HEART ATTACK & STROKE

Application for Supplemental Health Insurance
OREGON

Application Package Contains:

REQUIRED FORMS TO BE SUBMITTED	REQUIRED FORMS LEFT WITH APPLICANT(S)
• Authorization to Disclose Personal Information (HIPAA)/ MIB Authorization Form • Agent Producer Statement • Other State Special Forms (if applicable)	• Pre-Notices • Outline(s) of Coverage • Other State Special Forms (if applicable)

FORMS THAT MAY BE REQUESTED, BUT ARE NOT INCLUDED WITHIN THIS PACKAGE

The following forms can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application:

- Foreign Travel Questionnaire
- Replacement Notice

Application Instructions:

- Submit the fully completed application and applicable completed forms. Unanswered questions on the application or missing or incomplete forms will result in underwriting delays.
- If a question does not apply to your client, answer it as "No" or "None" rather than "N/A."
- **Mail application and appropriate forms to: Mutual of Omaha Insurance Company, Records/Mailing Processing Center, 9330 State Hwy 133, Blair, NE 68008-6179.**
- **Fax application to 402-997-1804 and verify the correct facsimile number is dialed to protect the privacy of the information.**

  Please note: use the maximum resolution to ensure the readability of the application.

MAP626_OR
1/1/2015

Manager/Commission Code (Required Field for Brokerage)

Mutual of Omaha Insurance Company

Application for Supplemental Health Insurance

Mutual of Omaha

GENERAL INFORMATION

Coverage(s) Applying For

Product: (Select only one)

☐ Lump Sum Cancer (Complete Sections A and B)

☐ Lump Sum Heart Attack and Stroke (Complete Sections A and C)

Base Lump Sum Benefit Amount $_____

Optional Riders:

☐ Cash Value Benefit Rider

☐ $250 ☐ $500 ☐ $750 ☐ $1,000

Intensive Care Unit Indemnity Benefits Rider (Complete Section D)

☐ Cancer Benefits Rider $ _____ (Complete Section B)

☐ Heart Attack and Stroke Benefits Rider $ _____ (Complete Section C)

Note: The lump sum benefit amount for any child(ren) under an applicable policy will equal the amount of the Primary Insured up to $50,000. Must select benefit in increments of $1,000.

Type of Coverage: ☐ Individual ☐ Individual plus child(ren) ☐ Family

Coverage Options: ☐ Guaranteed for lifetime ☐ 10 year term ☐ 15 year term ☐ 20 year term ☐ 30 year term

Proposed Insured Information

Proposed Insured's Name (First, Middle, Last)	Sex ☐ Female ☐ Male	Date of Birth / /
Primary Residence Address (Number, Street, City, State, Zip)	Ht. Wt.	Social Security Number - -
Mailing Address for Premium Notices (if different than primary address)	Telephone Number ( ) _____- _____	Best Time to Call _____ A.M. P.M.
Full Name of Beneficiary	Relationship to Proposed Insured	

All Other Persons Proposed For Insurance

Relationship	Name (First, Middle, Last)	Date of Birth	SS#	Sex	Ht.	Wt.
Partner *		/ /	- -			

Relationship	Name (First, Middle, Last)	Date of Birth	Sex
Child #1		/ /	
Child #2		/ /	
Child #3		/ /	
Child #4		/ /	

Are all applicants U.S. citizens or Permanent Resident Card holders who have resided in the U.S. for 3 years? Yes ☐ No ☐

If "No," Name(s) _____

* Partner means the one person who is (a) your spouse to whom you are legally married; (b) your registered domestic partner or civil union partner; or (c) an adult person who: 1. shares a serious and committed personal relationship with you that is intended to be lifelong; 2. has shared a common permanent residence with you on a continuous basis for the most recent three years; 3. is not married, a domestic partner, a civil union partner, or in a committed personal relationship to anyone else; and 4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

Other Coverage and Replacement Information

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

Company	Proposed Insured	Face Amount

HEALTH QUESTIONS

Please answer the questions below for the insurance type you are applying.

If the answer is Yes, any individual named will be excluded from coverage under this policy.

Section A: All Insurance Applied For:

1. Has any Proposed Insured been diagnosed with or treated for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or any AIDS related condition? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

2. Has any Proposed Insured been advised by a medical professional to undergo treatment, further diagnostic evaluation or testing, or recently had diagnostic tests performed where the results are still pending or were inconclusive for any medical condition? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

Section B: Cancer Insurance Applied For:

1. Is any Proposed Insured currently receiving treatment, ever had treatment, or been advised to have treatment for internal cancer, lymphoma, leukemia, or melanoma? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

2. Within the past 5 years, has any Proposed Insured had persistently abnormal PSA readings, or abnormal mammogram, pap smear, colonoscopy, or other cancer screening test where cancer has not been ruled out? . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

Section C: Heart Attack and Stroke Insurance Applied For:

1. Has any Proposed Insured ever been diagnosed with, treated for, or advised to have treatment for any disease, disorder, or abnormality of the heart or circulatory system? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

2. Has any Proposed Insured ever been diagnosed with, treated for, or advised to have treatment for carotid artery disease, peripheral artery disease, cerebrovascular disease, stroke, or TIA (Transient Ischemic Attack)? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

3. Within the past 6 months, has any Proposed Insured had 2 or more blood pressure readings of 140/90 or above? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

4. Has any Proposed Insured ever been diagnosed with diabetes? . . . . . ☐ **Yes** ☐ **No**

If "Yes," who? _____

Section D: Intensive Care Unit Benefit Rider Insurance Applied For:

1. Is any Proposed Insured currently bedridden, hospital confined, in a nursing home or assisted living facility, or confined to a wheelchair? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
2. Has any Proposed Insured been diagnosed and/or treated with any disease or disorder of the lung, liver, connective tissue, brain or nervous system? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
3. Has any Proposed Insured been advised to have surgery that has not been performed or recently had surgery from which he/she is not fully recovered? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**
4. Is any Proposed Insured currently pregnant? . . . . . If "Yes," who? _____	☐ **Yes** ☐ **No**

PLEASE READ AND SIGN

AGREEMENTS AND ACKNOWLEDGEMENTS

1. Applicant ("you") represents that my answers on this application are true and complete. Incorrect or misleading answers may void this application and any issued policy from its effective date.
2. Mutual of Omaha Insurance Company ("we" or "us") may require medical records, a medical exam or other information. This coverage will not be approved unless we receive all information requested for underwriting and determined 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 approved, the policy will indicate its effective date.
3. 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 coverage will be in effect until we issue a policy and receive payment of the full initial premium according to the premium mode you selected with your application.
4. No producer can waive or change any receipt or policy provision or agree to issue a policy.

NOTE: After the policy has been in effect for two years, Mutual of Omaha Insurance Company cannot use misrepresentations, except fraudulent misstatements, to void the policy. See the policy for details.

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

I also acknowledge receipt of an Individual Health Insurance Policy Disclosure Statement for the policy applied for.

Signed at: _____
City State

_____ _____ _____
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.)_____

I conducted said interview in person ☐ Yes ☐ No

(If "No," please explain.)_____

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

_____ _____
Office Name Office Address

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

_____ _____
Office Name Office Address

AGENT/PRODUCER STATEMENT

Proposed Insured: _____

CONTACT INFORMATION

Division Office/MGA _____ Phone Number _____

Contact (if different than above, who should we contact on this case)

Name _____ Phone Number _____

E-mail Address _____

COMMISSION INFORMATION

Producer Name _____ Production Number _____

Social Security Number _____ Commission % Share _____

If second producer, please complete below:

Producer Name _____ Production Number _____

Social Security Number _____ Commission % Share _____

ADDITIONAL INFORMATION

Do you have any reason to believe the policy applied for has replaced or will replace any existing insurance? ..... ☐ Yes ☐ No

NOTE: If Yes, fulfill all state requirements.

Has the MIB, Inc. Pre-Notice and the Notice of Information Practices been provided to the Proposed Insured where applicable?..... ☐ Yes ☐ No

If applying with spouse, enter spouse's name _____

Comments or Special Instructions:

_____

_____

_____

_____

_____

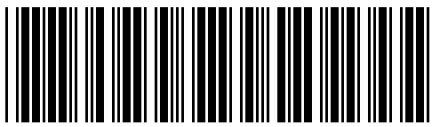
_____

_____

_____

Agent/Producer Signature _____ Date _____
Month/Day/Year

Agent/Producer Signature _____ Date _____
Month/Day/Year



Mutual of Omaha Insurance Company

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

PAYMENT AUTHORIZATION FORM

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

Payment Information

1. **Initial Premium Payment**

☐ Automated Bank Account Withdrawal ☐ Check Amount Collected $_____

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.

2. **Ongoing Premium Payments**

☐ Automated Bank Account Withdrawal (Monthly)

Specify the date premiums will be withdrawn: ☐ 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. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

☐ Direct Bill (select one) ☐ Annual ☐ Semiannual ☐ Quarterly

Payor Information

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)

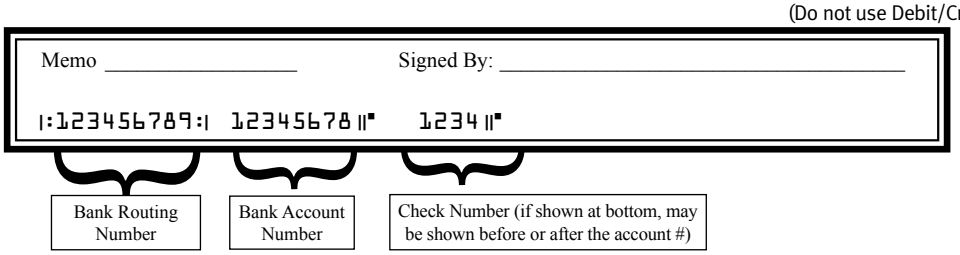
☐ Employer
☐ Business owned by Proposed Insured/Insured or Spouse
☐ Power of Attorney or legal guardian
☐ Living Trust
☐ Other _____

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)



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 the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

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

Oregon Individual Health Insurance Policy Disclosure Statement

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

_____ _____
(Agent or insurance company representative) (Address)

Completed this questionnaire on _____ for
(Date)

_____ _____
(Applicant) (Address)

describing _____ ,
(Policy name, form number)

an individual health insurance policy providing coverage for _____ .

This policy is underwritten by _____
(Insurance company or health care service contractor)

_____
(Address)

NOTICE

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

Are You Considering Replacing Your Current Coverage? Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage? Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read Your Policy! If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health are omitted from the application, the insurer may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

M9284_OR_0114

I acknowledge receipt of this Individual Health Insurance Policy Disclosure Statement and an Outline of Coverage for the Policy applied for.

_____ _____
(Applicant Signature) (Date)

Company Copy M9284_OR_0114

QUESTIONS AND ANSWERS

GENERALLY

1. Does the insurer have a list of doctors or hospitals, or both, under contract that are considered "preferred" or "participating"? YES ___ (Proceed to next question) NO ___ (Proceed to question 5)

2. May I use doctors or hospitals that are not on the list? YES ___ (Proceed to next question) NO ___ (Proceed to question 5)

3. Will I save money by using the doctors or hospitals on the list instead of others? YES ___ NO ___

4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and co-payments)? YES ___ NO ___

5. (If the coverage offered is comprehensive major medical) Pregnancy Benefits:

   (a) What are the policy's benefits and limitations with respect to pregnancy? (Include such applicable limitations as waiting periods and preexisting conditions periods)

   _____

   _____

   (b) Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy's issuance? YES ___ NO ___

Are You Replacing Coverage?

6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any waiting periods under the new policy, such as for preexisting condition limitations?
   YES ___ NO ___ OTHER (Explain) _____

7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles?
   YES ___ NO ___ OTHER (Explain) _____

8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance?
   YES ___ NO ___ If not, when will it be covered? _____

9. Does the policy contain any dollar limitations on specific benefits? YES ___ NO ___
   Any limits on specific benefits, such as hospitalization? YES ___ NO ___

   IF "YES" to either question, please explain:

   _____

   _____

Are You Adding Coverage to Your Current Policy?

10. If coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays? (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

M9284_OR_0114

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

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company or its reinsurers may make a brief report to MIB, Inc., a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply the information in its file to that company.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

In compliance with applicable law, Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. **Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.**

M26978_0809

GIVE THESE NOTICES TO THE APPLICANT

Important Notice to Persons on Medicare
This Is Not Medicare Supplement Insurance

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

✓ Check the coverage in all health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

M20180

Oregon Individual Health Insurance Policy Disclosure Statement

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

_____ _____
(Agent or insurance company representative) (Address)

Completed this questionnaire on _____ for
(Date)

_____ _____
(Applicant) (Address)

describing _____ ,
(Policy name, form number)

an individual health insurance policy providing coverage for _____ .

This policy is underwritten by _____
(Insurance company or health care service contractor)

_____
(Address)

NOTICE

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Are You Considering Adding to Your Current Coverage? Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

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We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

M9284_OR_0114

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_____ _____
(Applicant Signature) (Date)

Applicant Copy M9284_OR_0114

QUESTIONS AND ANSWERS

GENERALLY

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2. May I use doctors or hospitals that are not on the list? YES ___ (Proceed to next question) NO ___ (Proceed to question 5)

3. Will I save money by using the doctors or hospitals on the list instead of others? YES ___ NO ___

4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and co-payments)? YES ___ NO ___

5. (If the coverage offered is comprehensive major medical) Pregnancy Benefits:

   (a) What are the policy's benefits and limitations with respect to pregnancy? (Include such applicable limitations as waiting periods and preexisting conditions periods)

   _____

   _____

   (b) Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy's issuance? YES ___ NO ___

Are You Replacing Coverage?

6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any waiting periods under the new policy, such as for preexisting condition limitations?
   YES ___ NO ___ OTHER (Explain) _____

7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles?
   YES ___ NO ___ OTHER (Explain) _____

8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance?
   YES ___ NO ___ If not, when will it be covered? _____

9. Does the policy contain any dollar limitations on specific benefits? YES ___ NO ___
   Any limits on specific benefits, such as hospitalization? YES ___ NO ___

   IF "YES" to either question, please explain:

   _____

   _____

Are You Adding Coverage to Your Current Policy?

10. If coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays? (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

M9284_OR_0114

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

LUMP SUM CANCER INSURANCE COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare available from us.

THE POLICY PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR POLICY CP1

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!

Cancer Insurance Coverage – Policies of this category are designed to provide benefits ONLY when certain losses occur as a result of specified diseases. Coverage is NOT provided for other diseases or accidents.

BENEFITS – If a physician diagnoses an insured person with cancer while this policy is in force, we will pay 100% of the lump sum benefit shown on the policy schedule. Once we have paid 100% of the lump sum benefit for the primary insured, this policy will end, unless lump sum benefits continue under an attached rider.

COVERED CONDITION LIMITATION – The policy pays benefits only for loss resulting from cancer. It does NOT cover any other type of sickness or injury, unless such other coverage has been added by rider.

EXCLUSIONS – We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION – The policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 12 months or more after the policy effective date.

A pre-existing condition is a condition:

(a) for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within 12 months prior to the policy effective date; or
(b) which manifested itself within 12 months prior to the policy effective date in a manner that would have caused a reasonably prudent person to seek diagnosis, care or treatment by a physician.

30-DAY PROBATIONARY PERIOD – The policy has a 30-day probationary period for cancer. Subject to the Pre-Existing Condition Limitation provision requirements, in order to be covered, cancer must be:

(a) diagnosed while this policy is in force; and
(b) diagnosed at least 30 days after the policy effective date or at least 30 days after any policy reinstatement date.

If an insured person is diagnosed with cancer during the policy probationary period, we will not pay benefits for that insured person. Coverage for that insured person will end as of the policy effective date. We will refund any unearned premium for that insured person.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD – The policy is guaranteed renewable until we pay 100% of the primary insured's lump sum benefit, or until the term period shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before that time as long as you pay the required premium before the end of each grace period.

PREMIUMS CAN CHANGE – We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the policy effective date.

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

HEART ATTACK AND STROKE INSURANCE COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
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OUTLINE OF COVERAGE FOR POLICY CP2

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!

Heart Attack and Stroke Insurance Coverage – Policies of this category are designed to provide benefits ONLY when certain losses occur as a result of specified diseases. Coverage is NOT provided for other diseases or accidents.

BENEFITS – If a physician diagnoses an insured person with a covered condition while this policy is in force, we will pay a percentage of the lump sum benefit. The percentage payable for each type of covered condition is listed below. If we pay less than 100% of the lump sum benefit for a type of covered condition, the lump sum benefit remaining available for future claims for that insured person will be reduced by that amount. We will not reduce your policy's premium when a portion of the lump sum benefit is paid. Once we have paid 100% of the lump sum benefit for the primary insured, this policy will end, unless lump sum benefits continue under an attached rider.

Type of Covered Condition	Percentage of Lump Sum Benefit Payable
Heart Attack (Myocardial Infarction)	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE during the life of your policy)**

COVERED CONDITION LIMITATION – The policy pays benefits only for loss resulting from a covered condition. It does NOT cover any other type of sickness or injury, unless such other coverage has been added by rider.

EXCLUSIONS – We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION – The policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 12 months or more after the policy effective date.

A pre-existing condition is a condition:

(a) for which medical advice, diagnosis, care, or treatment was recommended by or received from a physician within 12 months prior to the policy effective date; or
(b) which manifested itself within 12 months prior to the policy effective date in a manner that would have caused a reasonably prudent person to seek diagnosis, care or treatment by a physician.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD – The policy is guaranteed renewable until we pay 100% of the primary insured's lump sum benefit, or until the term period shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before that time as long as you pay the required premium before the end of each grace period.

PREMIUMS CAN CHANGE – We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the policy effective date.