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

FULL UNDERWRITING

DI CHOICE PORTFOLIO

DI CHOICE- INDIVIDUAL

- ACCIDENT ONLY DISABILITY
- SHORT-TERM DISABILITY
- LONG-TERM DISABILITY
- BUSINESS OVERHEAD EXPENSE

Application for Disability Insurance

NEW YORK

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 • HIV Consent Form (if applicable) • Other State Special Forms (if applicable)	• Notice of Informational Practices / Pre-Notices • HIV Consent Form (if applicable) • 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:

- Alcohol Usage Questionnaire
- Drug Questionnaire
- Avocation Questionnaire
- 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.

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 ____________________

INDIVIDUAL DISABILITY

Occupational Class Quoted: (check one)

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ 1A

Discount Eligibility (check one)

☐ Association Group (Marketing verification form M27646 required)

Association Name ____________________

Association Number ____________________

Date Joined (Mo./Yr.) ____________________

☐ Self-Employed (submit financials)

☐ Common Employer

Group Number ____________________

Employer's Name ____________________ Address____________________

List all associated Common Employer Applicants____________________

____

☐ Life/DI

Life Policy Number ____________________

DI CHOICE AT WORK

(check if applies) Group Name ____________________ Group Number ____________________

☐ GSI (Mandatory) ☐ ESI

☐ GSI (Voluntary) ☐ Fully Underwritten

What type of application are you submitting? (Complete if applying for GSI or ESI only)

☐ Original Enrollment ☐ New Hire ☐ Annual Enrollment (ESI)

Occupation Class Quoted: (check one)

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ 1A

If business owner, has Business Owner Upgrade been applied? ☐ Yes ☐ No

UNDERWRITING REQUIREMENTS

Please check the underwriting requirements that have been ordered if applicable:

Type of Requirement:

- ☐ Client Interview (call 1-800-775-3000)
- ☐ Blood/Urine Profile/Physical Data

  Ordered Through:
  - ☐ American Para Professional Systems (APPS) 1-800-635-1677
  - ☐ Hooper Holmes 1-800-765-1010
  - ☐ Exam One 1-877-933-9261
  - ☐ Examination Management Services, Inc. (EMSI) 1-800-872-3674
  - ☐ Superior Mobile Medics 1-800-898-3926
- ☐ Long Form
- ☐ EKG

ADDITIONAL INFORMATION

Do you have any reason to believe the policy applied for has replaced or will replace any existing disability insurance coverage? .... ☐ Yes ☐ No
NOTE: If Yes, fulfill all state requirements.

Has the Notice of Information Practices been provided to the Proposed Insured?...................................... ☐ Yes ☐ No

If applying with spouse or business partner, enter name ____

Comments or Special Instructions:

____

____

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

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

Manager/Commission Code (Required Field for Brokerage)	

Mutual of Omaha Insurance Company

Application for Individual Disability Income Insurance

SECTION A — GENERAL INFORMATION - COMPLETE FOR ALL CASES

Coverage(s) Applying For

Program (must check one)
☐ DI Choice at Work (Group # ______________)
☑ Individual DI

Product (check at least one)
☐ Accident-Only Disability Income ☐ Long-Term Disability (LTD)
☐ Short-Term Disability (STD) ☐ Business Overhead Expense (BOE)

Proposed Insured Information

Proposed Insured's Name (First, Middle, Last) | Gender ☐ Male ☐ Female | Date of Birth | Birth State

Primary Residence Address (Number, Street, City, State, Zip) | Social Security Number

Mailing Address for Premium Notices (if different than above) | Telephone Number ( ) _______- _______ | Best Time to Call _________ A.M. P.M.

Full Name of Beneficiary | Relationship to Proposed insured

☐ U.S. Citizen
☐ Permanent Resident (Form I-551) Cardholder residing in the U.S. at least 3 consecutive years (Complete Foreign Travel Questionnaire)

During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? ☐ Yes ☐ No

Employment Information

☐ Employee (No Ownership) ☐ Sole Proprietor ☐ Partnership ☐ "S" Corp ☐ "C" Corp % Ownership _____ # of Employees _____

Employer | (City, State)

Occupation | List exact duties

1. Are you considered a full-time employee by your employer? ☐ Yes ☐ No # of hours/week _______________
2. How long have you been employed by your current employer? _____________________
3. Do you have any part-time or off-season occupation? ☐ Yes ☐ No (If "Yes," list exact duties/hours per week)

____

Other Coverage and Replacement Information

1. Are you covered under or eligible for: (Check all that apply)
☐ (FERS or CSRS) ☐ Railroad Retirement Act ☐ Workers Compensation

2. Are you currently applying for, or do you have in force other disability income coverage, such as: (a) Individual Disability Income; (b) Sick Pay, Association, Retirement/Pension Group Disability Plan; or (c) Business Expense or Buy/Sell Insurance? ☐ Yes ☐ No
If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (a,b,c)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
							☐ Yes ☐ No
							☐ Yes ☐ No

3. Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy. I am requesting termination of my Policy No. _________________ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

Income Information

1. Income information (Attach financial records if required. See underwriting guide for details)

	Year-to-Date	Prior Year	2nd Prior Year
(a) Gross Annual Earned Income	$ ______	______	______
(b) If **self employed**, net annual earned income from your occupation (after business expenses and before taxes)	$ ______	______	______
(c) Bonus, First Year Commissions and other incentive payments	$ ______	______	______
(d) Other Earned Income (Part-time, off-season, etc.)	$ ______	______	______
Total	$ ______	______	______

2. During the preceding tax year, did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed $1,500 per month?
☐ Yes ☐ No If "Yes," how much per month? ____________________

SECTION B — GENERAL UNDERWRITING INFORMATION

Complete For All Products

1. Have you been able to perform all the material and substantial duties of your job for the last 6 months? .... ☐ Yes ☐ No
2. Height (Ft & In) ______ Weight (Lbs) ______.
3. In the past 6 months, due to either an accident, sickness or chronic condition other than colds, flu or childbirth, have you . . .
   (a) missed 5 consecutive days or more of work? .... ☐ Yes ☐ No
   (b) been admitted to the hospital?.................... ☐ Yes ☐ No
4. In the past 2 years, have you applied for or received disability benefits? .... ☐ Yes ☐ No

   If "Yes", provide details/date ____________________
5. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, ski diving, hang gliding, skin or scuba diving?.......... ☐ Yes ☐ No
   (If "Yes," submit an Avocation Questionnaire)
6. In the past 3 years, have you been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, had four or more moving violations or had a driver's license suspended or revoked?.................... ☐ Yes ☐ No

   If "Yes", provide details ____________________
7. Have you filed for bankruptcy in the last 2 years?.................... ☐ Yes ☐ No

NOTE: If applying for Accident-Only Disability Income, proceed to Section C. Otherwise, proceed to Section D.

SECTION C — ACCIDENT-ONLY DISABILITY INCOME

To the best of your knowledge and belief, in the past 3 years, have you been diagnosed, received treatment or had any of the following conditions? Check all that apply.

- ☐ Alcoholism or Drug Abuse
- ☐ Alzheimer's or Dementia
- ☐ Bipolar, Manic Depression or Schizophrenia
- ☐ Cardiomyapathy
- ☐ Chronic back, neck or joint condition with ongoing treatment or treatment lasting more than 12 months
- ☐ Chronic or Recurring Neuritis (including Optic & Vestibular Neuritis)
- ☐ Epilepsy with seizure in the last 12 months
- ☐ Hemophilia
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Narcolepsy
- ☐ Parkinson's
- ☐ Pulmonary Embolism or Pulmonary Infarction
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma or Polymyositis
- ☐ Systemic Lupus Erythematosus (SLE)
- ☐ **None of These**

Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?.................... ☐ Yes ☐ No

If you answered "Yes", provide additional details below. Attach a separate signed sheet if necessary.

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Details of Treatment	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

NOTE: If applying for STD, LTD or BOE, proceed to Section D. Otherwise, proceed directly to Section F Plan Information.

SECTION D — COMPLETE FOR STD, LTD OR BOE

1. Are you pregnant? .... ☐ Yes ☐ No

2. In the past 10 years, have you been diagnosed, treated, hospitalized or prescribed medication for any disease or disorder associated with the following?

- ☐ Anemia or Blood
- ☐ Arthritis or Joints (including replacements)
- ☐ Breast or Male/Female Reproductive organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
- ☐ Cancer or Tumor
- ☐ Chronic Fatigue Syndrome
- ☐ Diabetes or Glandular Condition
- ☐ Fibromyalgia or Myalgia
- ☐ Heart or Coronary Arteries
- ☐ High Blood Pressure, Peripheral Vascular Disease
- ☐ Immune System (Including AIDS, ARC)
- ☐ Kidney or Urinary Tract
- ☐ Liver or Hepatitis
- ☐ Lung or Breathing Problem
- ☐ Major Organ Transplant
- ☐ Neurological condition (such as Multiple Sclerosis, Parkinson's, Seizures, Alzheimers, Muscular Dystrophy)
- ☐ Psychological, Emotional or Psychiatric condition
- ☐ Skin or Connective Tissue
- ☐ Spine, Neck or Back
- ☐ Stroke or Cerebral Vascular Condition
- ☐ Upper or Lower Digestive Tract
- ☐ **None of These**

3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)? .... ☐ Yes ☐ No
If "Yes," please list below. Attach a separate signed sheet if necessary.

Medication Name	Dosage / Frequency	Date Started	Reason	Prescribing Physician & Phone Number (if applicable)

4. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers or narcotics) other than as prescribed? .... ☐ Yes ☐ No
(If "Yes," submit a Drug or Alcohol Use Questionnaire)

5. Have you ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? .... ☐ Yes ☐ No
If "Yes," provide details/date ____.

6. Other than previously answered, during the last 5 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?.. ☐ Yes ☐ No
If you answered "Yes" to any of the above health questions, provide additional details below. Attach a separate signed sheet if necessary.

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Details of Treatment	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

NOTE: If applying for BOE, proceed to Section E. Otherwise, proceed directly to Section F Plan Information.

SECTION E — COMPLETE ONLY IF APPLYING FOR BUSINESS OVERHEAD EXPENSE INSURANCE

1. Is your business conducted at your place of residence?.. ☐ Yes ☐ No
If "Yes," what percent of your duties are performed outside of your place of residence? .... ____________ %
2. Date business established?... ________________
3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

Employees' Salaries	$ ____________	Water	$ ____________
Interest on loans	$ ____________	Telephone	$ ____________
Mortgage interest payments	$ ____________	Postage and stationery	$ ____________
Insurance (casualty/liability)	$ ____________	Equipment rental	$ ____________
Property taxes (real and personal)	$ ____________	Laundry	$ ____________
Depreciation (office equipment only)	$ ____________	Other fixed operating expenses (please itemize)	
Rent (including land rental)	$ ____________	________________	$ ____________
Electricity	$ ____________	________________	$ ____________
Heat	$ ____________	Total Monthly Expenses	$ ____________

SECTION F — PLAN INFORMATION

Accident Only Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period: ☐ 0 Days ☐ 7 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:
- ☐ Hospital Confinement Accident Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500
- ☐ Accident Medical Expense Rider ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

Short-Term Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period Accident/Sickness: ☐ 0/7 Days ☐ 7 Days ☐ 0/14 Days ☐ 14 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Benefit Period: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ 24 Months

Optional Riders:
- ☐ Hospital Confinement Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500
- ☐ Critical Illness Benefits Rider ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000
- ☐ Accident Medical Expense Rider ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

Long-Term Disability Insurance

Base Monthly Benefit Amount $____________________ **SIS Monthly Benefit Amount $** ______________

Elimination Period: ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Benefit Period: ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To Age 67

Optional Riders:
- ☐ SIS (Social Insurance Supplement) Benefits Rider
  - Do you have any dependent children age 17 or under? ☐ Yes ☐ No
  - Are you covered under the Social Security Act? ☐ Yes ☐ No
- ☐ Hospital Confinement Indemnity Benefits Rider
  - ☐ $125 ☐ $250 ☐ $350 ☐ $500
- ☐ Critical Illness Benefits Rider
  - ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000
- ☐ Accident Medical Expense Rider
  - ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000
- ☐ Extended Proportionate Disability Benefits Rider
- ☐ Future Insurability Option (FIO) Rider
- ☐ Extended Own-Occ. Disability Defin. Amend. Rider
- ☐ Cost-of-Living Adjustment (COLA) Rider

Business Overhead Expense Disability Insurance

Monthly Benefit Amount $____________________

Elimination Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

Benefit Period: ☐ 12 Months ☐ 18 Months

SECTION G — BILLING

Billing Directly to the Payor

Initial
- ☐ Check submitted with application
  - Amount collected $ ________________
- ☐ Automated Bank Account Withdrawal
- ☐ Collect on delivery

Renewal

Amount $ ______________
- ☐ Monthly (Automated Bank Account Withdrawal)
- ☐ Quarterly
- ☐ Semi-Annual
- ☐ Annual

Note: If Automated Bank Account Withdrawal is selected, please complete the Payment Authorization Form.

Payroll Deduction / List Bill

Requested Effective Date: _______________ Payroll Deduction (PRD) Group Number: _______________

SECTION H **PLEASE READ AND SIGN**

AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete to the best of my knowledge and belief and Mutual of Omaha Insurance Company ("Mutual of Omaha") will rely on these answers to determine insurability and (b) the application and any supplements shall become part of the applied for policy.
2. Applicant acknowledges that Mutual of Omaha may require: medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha, (b) Mutual of Omaha receives any additional information requested for underwriting, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha then in force.
4. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions under any temporary insurance agreement or conditional receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. A completed and signed application will become part of each applicant's policy.
6. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

FRAUD WARNING – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

______________________________ ______________________________ ______________________________

Signature of Payor as shown on bank account (if Billing Mode is BSP and Payor is other than Proposed Insured) | Printed Name of Payor | 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 | Date

______________________________ ______________________________

Office Name | Office Address

______________________________ ______________________________ ______________________________

Signature of Producer | Producer's Printed Name | Date

______________________________ ______________________________

Office Name | Office Address

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: ____________________

Complete this form only when authorizing a bank account withdrawal for premium payment.

Payment Information

1. **Initial Premium Payment**

☐ Automated Bank Account Withdrawal ☐ Check Amount Quoted $______________

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)

Memo ____________ Signed By: ____________________

⑆123456789⑆ 12345678⑈ 1234⑈

Bank Routing Number | Bank Account Number | Check Number (if shown at bottom, may be shown before or after the account #)

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

NEW YORK 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 reinstated.

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

Conditional Receipt

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

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ____ Signed at: ____
City State

____
Signature of Proposed Insured

____ ____
Signature of Producer Signature of Producer

Company's Copy

Mutual of Omaha Insurance Company
Companion Life Insurance Company

A Mutual *of* Omaha Company

Please check appropriate underwriting company

☐ **Mutual of Omaha Insurance Company** ☐ **Companion Life Insurance Company**

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result ______________________

____

Address ______________________

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This form will not attach to or become part of the policy.

Name of Proposed Insured ______________________

Address ______________________

____
Signature of Proposed Insured or Parent/Guardian if under age 18

____
Date Signed

PLEASE SUBMIT

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 (TTY 866-346-3642). 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

Conditional Receipt

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

☐ **Initial Premium paid by check**
Money was collected - Received $____________________ from ______________________ paid with an insurance application on ____, dated ____________________
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if all of the following conditions have been completely met:

1. Written application.
2. Payment of the full initial premium.
3. Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory) required by Mutual of Omaha Insurance Company.
4. Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
5. Satisfying Mutual of Omaha Insurance Company underwriting standards.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by Mutual of Omaha, no insurance coverage will be provided under this Conditional Receipt, and Mutual of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum benefit payable under this Conditional Receipt will be the lesser of: (a) the total benefit payable under all pending applications with Mutual of Omaha relating to the person proposed for insurance, or (b) $50,000. This Receipt provides no coverage for policy Riders.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date Mutual of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either Mutual of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

If you are eligible, the effective date of the insurance will be the date of the application, or the date the number of applications received from members of your group meets the minimum participation requirements, whichever date is later. **If you are not eligible, no insurance or temporary or interim insurance of any kind will be in effect.**

In no event will benefits be paid for the same loss under both this Conditional Receipt and any insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability.

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: ____ Signed at: ____
City State

____
Signature of Proposed Insured

____ ____
Signature of Producer Signature of Producer

Applicant's Copy

Mutual of Omaha Insurance Company
Companion Life Insurance Company
A Mutual *of* Omaha Company

Please check appropriate underwriting company

☐ **Mutual of Omaha Insurance Company** ☐ **Companion Life Insurance Company**

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result ______________________________

____

Address ______________________________

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This form will not attach to or become part of the policy.

Name of Proposed Insured ______________________________

Address ______________________________

____
Signature of Proposed Insured or Parent/Guardian if under age 18

____
Date Signed

MLU17109_0112

GIVE THIS COPY TO THE APPLICANT

Mutual *of* Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Long-Term Disability Income Insurance Coverage – Outline of Coverage

For Policy Form D81-21098 and D81-21099

REQUIRED DISCLOSURE STATEMENT

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D81-21098 is 55%. The expected benefit ratio for Policy Form D81-21099 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from a covered accident or sickness, subject to any limitations set forth in the policy. This coverage does NOT provide basic hospital, basic medical-surgical, or major medical insurance as defined by the New York State Insurance Department.

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 Benefit Period.

Proportionate Disability Benefits

If you are Proportionately Disabled because of Sickness or Injury and incur a 20% or greater Loss of Monthly Income, we will pay a percentage of your Total Disability Monthly Benefit that is proportionate to your lost income.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits under your policy for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

Transplant Donor Benefits

If you become Totally Disabled or Proportionately Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits under your policy and any Social Insurance Substitute Benefits Rider on the same basis as any other Sickness.

Terminal Illness Benefit

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy and any Social Insurance Substitute Benefits Rider.

Survivor Benefit

Upon your death, we will pay a Survivor Benefit to your designated Beneficiary, if Total or Proportionate Disability benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Proportionate Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form delivered or issued for delivery in New York to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

Exclusions and Limitations

Benefits are not payable 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 caused by intentionally self-inflicted injury;

(d) loss resulting from commission or attempted commission of a felony;

(e) loss caused by suicide or attempted suicide; or

(f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Substance Abuse Limitation

Benefits payable for Substance Abuse are limited to a lifetime maximum of 24 months.

Mental or Nervous Disorder Limitation

Benefits payable for Mental or Nervous Disorders are limited to a lifetime maximum of 24 months.

Military Service/Armed Forces Exclusion and Suspension of Coverage

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium within 60 days following active duty termination. Coverage will be retroactive to the date the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

(a) any loss resulting from an Injury or a Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and

(b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

Benefits Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D81-21099 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/ association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Optional Benefit – REQUIRED DISCLOSURE STATEMENT

Specified Disease Benefits Rider

If you receive a Diagnosis of a Specified Disease Insured Condition, we will pay the Specified Disease Benefit. The Specified Disease Benefit is payable on a one-time basis. Once benefits are paid, this rider will terminate.

Specified Disease Insured Conditions include Alzheimer's Disease, Heart Attack (Myocardial Infarction), Life-Threatening Cancer (when first symptoms appear and first Diagnosis occurs more than 30 days after the Rider Date or the rider reinstatement date), Major Organ Transplant, Paralysis, Renal Failure and Stroke.

Specified Disease Insurance Coverage

This optional rider provides specified disease coverage ONLY, subject to any limitations set forth in the rider. This rider does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

Exclusions and Limitations

The Exclusions and Limitations shown in the policy apply to this rider.

Read Your Rider Carefully

This outline of coverage provides a very brief description of the important features of your rider. This is not the insurance contract and only the actual rider provisions will control. The rider itself sets forth in detail the rights and obligations of both you and Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR RIDER CAREFULLY!

The expected benefit ratio for this rider is 55%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, which averaged over all people with this rider.

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Short-Term Disability Income Insurance – Outline of Coverage

For Policy Form D82-21100 and D82-21101

REQUIRED DISCLOSURE STATEMENT

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D82-21100 is 55%. The expected benefit ratio for Policy Form D82-21101 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from a covered accident or sickness, subject to any limitations set forth in the policy. This policy does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Insurance Department.

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 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 Benefit Period.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if Sickness or Injury results in the complete and irrecoverable loss of your:

(a) speech;

(b) hearing in both ears;

(c) sight in both eyes; or

(d) the use of both hands, both feet or one hand and one foot.

Transplant Donor Benefits

If you become Totally Disabled or Partially Disabled as the result of a transplant of part of your body to the body of another person, we will pay benefits on the same basis as any other Sickness.

Terminal Illness Benefit

If you are diagnosed with a Terminal Illness, you can elect to receive an accelerated payment of the remaining Total Disability Monthly Benefits due in a lump sum amount. This Terminal Illness Benefit may accelerate up to 12 months of the current benefits payable under your policy.

Survivor Benefit

Upon your death, we will pay a survivor benefit to your designated Beneficiary, if Total or Partial Disability Benefits were payable; and the Benefit Period was not exhausted.

Rehabilitation Benefit

While you are receiving Total Disability or Partial Disability benefits, we may pay for a vocational rehabilitation program.

Guaranteed Renewable to Age 67, Conditionally Renewable Thereafter to Age 75

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due. After Age 67, you may continue your coverage to Age 75 provided you maintain Full-Time Employment and pay the necessary premium when due.

Premium Changes

Your policy's premium may change before Age 67, but only if the same change is made to all policies of this form delivered or issued for delivery in New York to persons of the same Class. After Age 67, the premium will increase every year because the premium rate is then based upon your attained age. The premium may also change for other reasons after Age 67, but only if we make the same change on a Class basis. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

Exclusions and Limitations

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 caused by intentionally self-inflicted injury;

(d) loss resulting from commission or attempted commission of a felony;

(e) loss caused by suicide or attempted suicide;

(f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;

(g) loss resulting from Substance Abuse; or

(h) loss resulting from Mental or Nervous Disorders.

Pregnancy

Benefits are not payable for loss due to Normal Childbirth, Normal Pregnancy or voluntarily induced abortion. We will pay benefits for Complications of Pregnancy on the same basis as any other Sickness.

Military Service/Armed Forces Exclusion and Suspension of Coverage

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium within 60 days following active duty termination. Coverage will be retroactive to the date the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

(a) any loss resulting from an Injury or a Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and

(b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

Benefit Reduction When Association Group Membership or Self-Employment Ends

(Policy Form D82-21101 Only)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Optional Benefit – REQUIRED DISCLOSURE STATEMENT

Specified Disease Benefits Rider

If you receive a Diagnosis of a Specified Disease Insured Condition, we will pay the Specified Disease Benefit. The Specified Disease Benefit is payable on a one-time basis. Once benefits are paid, this rider will terminate.

Specified Disease Insured Conditions include Alzheimer's Disease, Heart Attack (Myocardial Infarction), Life-Threatening Cancer (when first symptoms appear and first Diagnosis occurs more than 30 days after the Rider Date or rider reinstatement date), Major Organ Transplant, Paralysis, Renal Failure and Stroke.

Specified Disease Insurance Coverage

This optional rider provides specified disease coverage ONLY, subject to any limitations set forth in the rider. This rider does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

Exclusions and Limitations

The Exclusions and Limitations shown in the policy apply to this rider.

Read Your Rider Carefully

This outline of coverage provides a very brief description of the important features of your rider. This is not the insurance contract and only the actual rider provisions will control. The rider itself sets forth in detail the rights and obligations of both you and Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR RIDER CAREFULLY!

The expected benefit ratio for this rider is 55%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, which averaged over all people with this rider.

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Accident-Only Short-Term Disability Income Insurance Coverage – Outline of Coverage

Important Notice – This Policy Does Not Provide Coverage for Sickness

Required Disclosure Statement

For Policy Form D83-21102 and D83-21103

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 Mutual of Omaha Insurance Company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

The expected benefit ratio for Policy Form D83-21102 is 55%. The expected benefit ratio for Policy Form D83-21103 is 60%. This ratio is the portion of future premiums which Mutual of Omaha Insurance Company expects to return as benefits, when averaged over all people with this policy.

Accident Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, disability income insurance coverage for loss resulting from covered ACCIDENTS only, subject to any limitations set forth in this policy. This policy does NOT provide basic hospital, basic medical, or major medical insurance, as defined by the New York State Insurance Department.

Total Disability Benefits

If you are Totally Disabled because of an 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 Benefit Period.

Partial Disability Benefits

If you are Partially Disabled because of an 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 Benefit Period.

Presumptive Total Disability Benefits

We will automatically pay Total Disability Benefits for the full length of the Benefit Period upon proof of your presumptive Total Disability. Benefits are payable even if you return to work at any occupation. The Elimination Period will be waived. Regular Medical Care will not be required. You will be presumed to be permanently Totally Disabled if an Injury results in the complete and irrecoverable loss of your:

(a) speech;
(b) hearing in both ears;
(c) sight in both eyes; or
(d) the use of both hands, both feet or one hand and one foot.

Survivor Benefit

Upon your death, we will pay a Survivor Benefit to your designated Beneficiary, if Total or Partial Disability benefits were payable; and the Benefit Period was not exhausted.

Guaranteed Renewable to Age 67

You are guaranteed the right to continue your coverage until Age 67. During that time, we cannot cancel your policy as long as you pay the required premium when it is due.

Premium Changes

Your policy's premium may change, but only if the same change is made to all policies of this form delivered or issued for delivery in New York to persons of the same Class. In no event will the premium increase during the first 12 months following the Policy Date. All premium changes are subject to approval by the New York State Insurance Department.

Exclusions

This policy pays benefits for loss resulting from covered Injuries only. We will not pay benefits for:

(a) injuries that occur while this policy is not in force;

(b) loss resulting from an act of declared or undeclared war;

(c) loss caused by intentionally self-inflicted injury;

(d) loss resulting from commission or attempted commission of a felony;

(e) loss caused by suicide or attempted suicide; or

(f) loss sustained or contracted in consequence of your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician;

Military Service/Armed Forces Exclusion and Suspension of Coverage

Benefits are not payable for loss sustained while serving in the military or the armed forces. Upon notice to us of entry into the military or armed forces, the unearned portion of the premium will be refunded.

If you enter into full-time military service, or are a member of a reserve component of the United States armed forces, including the National Guard, you can request to have your coverage suspended during a period of active duty. Such request must be made in writing. During this time, your policy will not be in force and no premium will need to be paid by you. Once the period of active duty ends, we will resume your coverage upon our receipt of your written application and payment of the required premium within 60 days following active duty termination. Coverage will be retroactive to the date of the period of active duty ended. Your renewed policy will be subject to the same terms and conditions as before suspension of coverage, except:

(a) any loss resulting from an Injury or Sickness which arose during the period of active duty will not be covered if the condition has been determined by the secretary of Veterans Affairs to be a condition incurred in the line of duty; and

(b) any Elimination Period not satisfied prior to suspension of coverage must be completed following resumption of coverage. In no event will the combined days applied to the Elimination Period before and after suspension exceed the length of the original Elimination Period.

Suspension of coverage will be allowed for up to five years of continuous active duty. Active duty does not include any period of service dedicated to training or determination of your physical fitness.

We will refund the portion of any premium paid which applies toward a period of suspended coverage.

Benefits Reduction When Association Group Membership or Self-Employment Ends

(**Policy Form D83-21103 Only**)

This policy form was issued to you because you are self-employed or a member of a franchise/association group. If your franchise/association membership ends, the organization ceases to endorse this product, or you stop being self-employed, you may continue this coverage. Premiums will not increase as a result of this change. However, all benefits payable for loss beginning after such time will be reduced by 15%.

Workers' Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal workers' compensation, employer's liability, or occupational disease law will be reduced by 50%.

Mutual *of* Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Overhead Expense Protection Summary of Coverage

For Policy Form 151BE

This coverage provides benefits for the operating expense of a business or a practice when the owner/Insured is completely unable to engage in his or her occupation as a result of covered illness or injury, receives no earnings for performing other work or service and receives medical treatment. Benefits of your plan are as indicated in your policy.

Renewal Agreement

We will renew your policy each time you send us the premium until you reach age 65. However, the policy will terminate when you retire, sell your business, discontinue your business or the practice of your business or profession.

Premium Change

Your premium cannot be changed unless we make the same change on all policies of this form issued to persons of the same classification in your state.

Tax Deductible

Your Overhead Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings which allow certain business and professional men and women who are sole proprietors, partners and stockholders/employees of a business to use premiums for the policy as direct business expense for tax deduction. This is based on current tax code.

Preexisting Sickness or Injury

Means a sickness or injury which first makes itself known or is medically treated before the Policy Date and which must be disclosed as requested on the application. Benefits are payable for such preexisting sickness or injuries made known to us on the application and not excluded from coverage. Benefits for such conditions shown on the policy Schedule will be payable only for such loss which starts after the policy has been in force at least 12 months.

Exceptions

Benefits are not payable for: loss beginning while the policy is not in force; loss resulting from suicide; loss resulting from air travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; loss caused by an act of declared or undeclared war; or childbirth, pregnancy or complications resulting therefrom.

We will not be liable for any loss that results from being under the influence of any narcotic unless administered on the advice of a physician.

Monthly Operating Expense Benefits

When injuries or sickness results in total loss of time, we will pay benefits for operating expenses you incur during such total loss of time. Benefits are subject to the deductible (or elimination) period. Benefits for actual operating expenses incurred each month will be paid up to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense for one accident or sickness.

If benefits are payable for less than one month, the benefit payable for each day will be 1/30th of the average monthly operating expense as determined above.

Operating Expenses

Operating Expenses include: rent; electricity, heat, water and other utilities; telephone; laundry; accountant's service; salaries of employees; taxes; depreciation on office equipment; deterioration of supplies; payments of interest on business debts but not principal, postage and stationery; monthly prorate of annual charitable contributions; telephone answering service; prorate of business insurance premiums; membership fees and dues for professional and business societies or associations; subscription charges for business or professional periodicals; maintenance service and such other fixed expenses as are normal and customary in the conduct and operation of your office or business. In the event of joint occupancy or partnership, only your portion of such expenses is covered.

Operating expenses do not include: your salary; fees; drawing accounts or any other compensation received by you nor the cost of goods; wares; pharmaceutical products or professional books; equipment or other items not specifically named in your policy.

Other Features of Your Plan

Conversion Privilege

Regardless of changes in your health, upon your written request for conversion of the policy, the Company agrees to issue an individual loss of time policy to replace this coverage. Written request must be submitted prior to the Insured's 60th birthday, and the Insured must then be regularly and gainfully employed on a full-time basis.

Waiver of Premium

The Company will waive premiums on the policy after total loss of time benefits have been paid continuously for three months. This waiver applies only to those premiums becoming due after such three-month period.

Coverage Underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175, 402 342 7600

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Contains a Recurrent Provision

In the event of further total loss of time as a result of sickness or injuries for which benefits have been payable, the Maximum Operating Expense Benefit and Deductible Period will be restored after the Insured returns to work on a full-time basis for a period of six consecutive months.

Suspension of Coverage While in an Armed Service and Subsequent Renewal

When you enter an armed service, coverage will be suspended for the period of such service. Upon your written request, any unearned premium will be returned. If you are in the service for less than five years, your policy may be renewed on the date your service ends if we receive your written application and premium within 60 days of your discharge. Your policy will be renewed on the same basis as before it was suspended and without restriction for preexisting conditions, except any that may be applied prior to the date of suspension.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 55%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy.

Grace Period

A grace period of 31 days will be granted for the payment of renewal premiums.

This is a brief description of some of the important features and benefits of this Overhead Expense Protection Plan. Additional information may be found in the brochure.

However, the policy itself details the rights and obligations of both you and Mutual of Omaha Insurance Company. PLEASE READ YOUR POLICY CAREFULLY.

Policy Form 151BE

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