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

FLORIDA

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
- Avocation Questionnaire
- Replacement Notice
- Drug Questionnaire
- Foreign Travel Questionnaire

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 _____

UNDERWRITING PROGRAMS/DISCOUNTS

DI Choice (check if applies)

☐ Association Group (Marketing verification form M27646 required)

Association Name _____

Association Number _____

Date Joined (Mo./Yr.) _____

☐ Self-Employed (submit financials)

DI Choice at Work (check if applies) Group Name/Number _____

☐ GSI (Mandatory)

☐ GSI (Voluntary)

☐ ESI

☐ Fully Underwritten

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

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

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

Occupation Class Quoted: (check one)

☐ 6A ☐ 5A ☐ 4A ☐ 3A ☐ 2A ☐ 1A

DI Choice at Work only:
If business owner, has Business Owner Upgrade been applied? ☐ Yes ☐ No

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
☐ 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.

4. Complete only if replacing any other policy. Company Name _____ Policy No. _____

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**

To the best of your knowledge and belief, 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. To the best of your knowledge and belief, 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, HIV)
- ☐ 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. To the best of your knowledge and belief, 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 Rider:

☐ Hospital Confinement Accident Indemnity Benefits Rider ☐ $125 ☐ $250 ☐ $350 ☐ $500

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

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

☐ 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 and Mutual of Omaha Insurance Company ("Mutual of Omaha") will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false , incomplete, or misleading information is guilty of a felony of the third degree.

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

Agent 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 Agent Agent's Printed Name Florida License # Date

_____ _____
Office Name Office Address

_____ _____ _____
Signature of Agent Agent's Printed Name Florida License # 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 IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, 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) ☐ Direct Bill

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 same day of the month as the policy date or 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 placed inforce.**

Payor Information

Name of payor as shown on bank account: _____ Birthdate:_____

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)

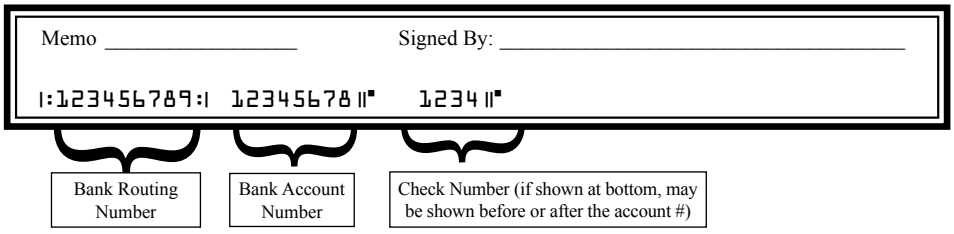
☐ Employer
☐ Business owned by Proposed Insured/Insured or Proposed Insured/Insured's spouse
☐ Power of Attorney or legal guardian
☐ Living Trust
☐ Other _____

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 _____ X _____

Mo./Day/Yr. Authorized Signature as Shown on Account Joint Account or Other Authorized Signature

Florida – Authorization To Disclose Personal Information To Mutual of Omaha Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Mutual of Omaha Insurance Company.

Purposes

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

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

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

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that 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 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

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

Printed Name of Proposed Insured	Spouse's Printed Name (If Proposed Insured)	If children are to be insured, their printed names
Signature of Proposed Insured	Signature of Spouse (If Proposed Insured)	Signature of Parent or Guardian (If Proposed Insured is a Minor)
Date	Date	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Receive Information From and Disclose Information to MIB, Inc.

Meanings of Terms

"MIB, Inc." means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Receive and Disclose

To MIB, Inc.:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to MIB, Inc. I understand that the 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 I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Individual Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

_____

_____

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Spouse (If Proposed Insured) Date

_____ _____
Signature of Parent or Guardian (If Proposed Insured is a Minor) Date

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.

Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for _____

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed; or
   (c) The date this Agreement is signed by both parties.

2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
   (a) 90 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy/certificate applied for; or
   (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
   (d) The date the premium refund is mailed; or
   (e) The date Mutual mails notice of termination of coverage.

3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**

4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**

6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor dies the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____at _____
(Month) (Year) City State ZIP Code

_____ _____ _____
Agent/Producer's Signature Signature of Proposed Insured Please Print Name

Company's Copy

Notice and Consent for AIDS Related Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

To evaluate 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 to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by certified laboratory through a medically accepted procedure. Many public health organizations have recommended that before taking an AIDS-related test, a person seeking counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

The HIV Antibody Test

A series of tests will be performed by a licensed laboratory through a medically accepted procedure to determine whether you may have been infected with the HIV virus. This test is not a test for acquired immunodeficiency syndrome (AIDS). AIDS is a disease you get when HIV destroys your body's immune system, and can only be diagnosed by medical evaluation.

An initial ELISA blood test will be done. If the initial ELISA test is positive, then a repeat ELISA test will be performed. If the second ELISA test is positive, a Western Blot test will be conducted to confirm the positive ELISA test results.

Potential Uses

The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. 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.

Limitations

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. 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 for reporting a positive test result _____

Address _____

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 fluid from me, the testing of that blood and/or other bodily fluid, 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.

Name of Proposed Insured _____

Address _____

_____ _____

Signature of Proposed Insured or Parent/Guardian 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.

M26414

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

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.

Temporary Insurance Agreement and Receipt ("Agreement")

Mutual of Omaha Insurance Company ("Mutual"), Mutual of Omaha Plaza, Omaha, NE 68175

Policy/Certificate form (rider) applied for _____

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, Mutual agrees to provide temporary insurance for the Proposed Insured, subject to the following conditions and limitations:

1. The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured lives, on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed; or
   (c) The date this Agreement is signed by both parties.

2. The temporary insurance provided by this Agreement will automatically terminate at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
   (a) 90 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy/certificate applied for; or
   (c) The date a policy/certificate, other than as applied for, is offered by a producer to the Proposed Insured; or
   (d) The date the premium refund is mailed; or
   (e) The date Mutual mails notice of termination of coverage.

3. The temporary insurance provided by this Agreement is subject to the provisions of the policy/certificate form applied for and accepted for issuance in this state, and has the same benefits as such policy/certificate form and series; **but in no event shall benefits be payable for more than one year after the date a claim begins under this Agreement.**

4. **That no insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5. **In no event will benefits be paid for the same loss under both this Agreement and any policy/certificate issued from the application.**

6. If any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

This Agreement does not limit Mutual in Applying its underwriting standards to the application, nor dies the Agreement limit or waive any rights under any policy/certificate issued. If the application is rejected by Mutual, the amount paid with the application will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the producer.

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____at _____
(Month) (Year) City State ZIP Code

_____ _____ _____
Agent/Producer's Signature Signature of Proposed Insured Please Print Name

Applicant's Copy

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 D81-21283

Read Your Policy Carefully

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

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the 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 and any Social Insurance Supplement Benefits Rider 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 Supplement 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 Supplement 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 issued to persons of the same Class who reside in the same state you do. 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. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

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 sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

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

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri); or

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by 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.

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 D82-21284

Read Your Policy Carefully

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

Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of a Sickness or Injury, we will pay the Total Disability Monthly Benefit. Total Disability benefits begin after the Elimination Period has been satisfied. Benefits are payable while you remain Totally Disabled for as long as the 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 Proportionate 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 issued to persons of the same Class who reside in the same state you do. 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. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

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 sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

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

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician);

(h) loss for which benefits are provided under any state or federal worker's compensation, employer's eligibility or occupational disease law;

(i) loss resulting from substance abuse; or

(j) 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.

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

This Policy Covers Accidents Only
It Does Not Pay Benefits For Loss Resulting From Sickness

For Policy Form D83-21285

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!

Accident Disability Income Insurance Coverage

Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident ONLY, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Total Disability Benefits

If you are Totally Disabled because of 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 Proportionate 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 issued to persons of the same Class who reside in the same state we do. We will give you at least 45 days advance written notice before any premium change. In no event will the premium increase during the first 12 months following the Policy Date.

Exclusions

We will not pay benefits for:

(a) loss that begins while this policy is not in force;

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

(c) loss sustained while serving in the armed forces (upon notice to us of entry into the armed forces, the unearned portion of the premium will be refunded);

(d) loss caused by intentionally self-inflicted injury (while sane in Colorado);

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

(f) loss caused by suicide or attempted suicide, while sane or insane (sane only in Colorado and Missouri);

(g) loss resulting from your being legally intoxicated or under the influence of an illegal substance or a narcotic (except for narcotics given on the advice of and taken as prescribed by a Physician); or

(h) loss resulting directly or indirectly from disease or bodily infirmity;

(i) loss for which benefits are provided under any state or federal worker's compensation, employer's liability or occupational disease law.

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

Business Operating Expense Summary of Coverage

For Policy Form 150BE

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 (in CT, IA & VA, unable to engage in substantial and material duties of 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, or 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 (and series in AL) issued to persons of the same classification in your state. In SC, you will receive at least 31 days' notice of a premium change.

Accidental Death Benefit (Not available in SC)

An amount equal to the total annualized premium of the policy and all riders in effect on the date of a covered accident, multiplied by the number of full years the policy has been in force, will be paid when such injury results in the Insured's death within 90 days (180 days in UT) after the date of the accident. This benefit is paid in addition to any other benefit under the policy. If there is a change of Insured, the Policy Date for this provision will be the date such change takes effect (not applicable in TN). (In TN, the minimum benefit is $1,000).

In VA, benefit is payable if injuries you receive while the policy is in force cause your death within: (a) 90 days of the accident or (b) 12 months of the accident if, as a result of the accident, you suffered continuous total disability that began within 30 days of the accident. The benefit is an amount equal to the total annualized premium of the policy and all riders in effect on the date of the accident, multiplied by the number of full years the policy has been in force. It is payable in addition to any other benefit. The minimum benefit is $1,000.00. If there is a change of Insured, the Policy Date, for this provision will be the date such change takes effect. Benefits are not payable for loss caused by suicide while sane or insane, an act of declared or undeclared war or sustained while in an armed service.

Tax Deductible

Your Business Operating Expense Policy has been designed to meet the requirements of Internal Revenue Service rulings which allow certain business professionals 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 (Not applicable in PA)

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. In MA, a sickness or injury makes itself known when the symptoms are clear enough to cause a prudent person to seek medical attention. 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. In AR, a sickness or injury for which medical advice or treatment was recommended by or received from a physician within five years from 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.

In CT, IA & WA, benefits will not be payable for loss caused by any condition, which makes itself known during the five-year period prior to the date the person suffering the loss became insured. A condition will be considered to have made itself known when medical care or treatment has been given, or there exist symptoms which could cause an ordinarily prudent person to seek diagnosis, care or treatment. In CT, this provision does not affect our rights with respect to any material misrepresentations contained in the application.

In VA, Subject to the Time Limit on Certain Defenses provision, benefits are not payable under the policy for loss caused by any condition which makes itself known during the two-year period prior to the Policy Date. A condition will be considered to have made itself known when: (1) medical advice or treatment has been received from a physician; or (2) there exist symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Exceptions

Benefits are not payable for: (a) loss beginning while the policy is not in force; (b) loss resulting from suicide while sane or insane (in MO, while sane only); (c) loss resulting from air

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

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travel unless sustained while a passenger (not as a pilot or member of the crew) for transportation only; (d) loss caused by an act of declared or undeclared war; (e) loss sustained while in an armed service (upon notice to the Company of entry into such service, the pro rata premium will be refunded); (f) normal childbirth, normal pregnancy or voluntarily induced abortion; or in MN childbirth or pregnancy; (g) in AR, loss resulting from certain pregnancy related conditions; (h) in KS, NH, PR and WA, childbirth, pregnancy or complications resulting therefrom; (l) in MN, alcoholism, drug addition or drug dependence.

In CO, FL, ID, MN, NC & UT, benefits are payable for complications of pregnancy on the same basis as any other covered sickness.

In MT & UT, subject to all policy provisions and limitations, maternity is payable on the same basis as any other sickness.

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 (not applicable in NM and VT).

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 operating expenses incurred each month will be paid up to the average monthly (in PA, the maximum) operating expenses for the 12-month period immediately before the start of the total loss of time. Benefits are limited to the Maximum Monthly Benefit, but not to exceed in the aggregate, the Maximum Operating Expense Benefit for one accident or sickness.

In MA, PA, SC & VA, 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. In TN, a pro rata benefit will be paid for a loss of less than one month.

A pro rata benefit will be paid for a loss of less than one month (TN only).

In the event that your average monthly operating expense decreases, the monthly benefits of your policy will be continued during a period of total loss of time until the Maximum Operating Expense Benefit is paid (not applicable in PA).

In NC, upon your written request, the Maximum Monthly Benefit may be increased. The increase will be effective on the first day of the calendar month following the date we receive your request and evidence of insurability. This adjustment cannot exceed the amount nearest your monthly office operating expense reported. A corresponding premium adjustment will also be made.

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.

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.

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 Business Operating Expense Policy. 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 150BE (in ID, Form 150BE Series-10116; in OK, Form 150BE Series-8972; in OR, Form 150BE Series-13316; in PA, Form 150BE Series-10501; in TX, Form 150BE Series-9068) or state equivalent.

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