A Guide for Successfully Completing the Mutual of Omaha Group Disability Continuation Request Form

Mutual of Omaha appreciates the opportunity to provide you with continued disability insurance protection. So that we can effectively process your request for insurance under our disability continuation plan(s), we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

About the Form

The Group Disability Continuation Request Form is a request for insurance under Mutual of Omaha's Disability Continuation Plan(s). Insurance under a continuation plan is available to employees when insurance under a Mutual of Omaha group disability insurance plan offered by an employer/group ends for certain reasons.

A completed and signed form with initial premium payment MUST be mailed to Mutual of Omaha within 31 days after insurance has ceased under the group plan for your request to be considered.

All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the employer/benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

Section 1: Group and Employee Eligibility Information

Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. Information regarding the employee's eligibility, and identification of the coverage(s) eligible for continuation, must also be provided.

Short-Term Disability (STD) and/or Long-Term Disability (LTD), is only eligible for continuation if the group policy for the specific insurance contained a continuation provision rider, either Portability or Conversion.

Section 2: Applicant Information

Please provide all required applicant information. The applicant must be age 69 or less to be eligible for insurance.

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via e-mail.

Section 3: Continuation Insurance Election

Indicate the type of disability insurance you wish to continue, either STD only, LTD only, or both. Remember, insurance is only eligible for continuation if the group policy for the specific insurance contained a continuation provision rider, either Portability or Conversion.

Section 4: Monthly Rates

These are the monthly rates for insurance under the continuation plans. The rates are age banded, which means that the premium for insurance is assessed according to age – as you age and advance to the next age band, the premium for your insurance will increase accordingly. The initial premium payment is based on your current age.

The rates presented in Section 4 are used in Section 5 to determine the premium for your insurance under the continuation plans.

Section 5: Benefit Amount and Initial Premium Payment Calculation

Complete this section for the insurance you are requesting continuation of, either STD, LTD or both. Work through the steps to determine your benefit amount, as well as your quarterly premium for the insurance.

Determining the Maximum Benefit (Steps "D" or "L") – The disability continuation plans will replace up to 60 percent of your income in effect at the time your insurance under the employer's group plan ended. Insurance is available on a guarantee issue basis (automatically available without provision of health information) for:

- Up to $700 of weekly benefit for STD (the STD Guarantee Issue Amount)
- Up to $3,000 of monthly benefit for LTD (the LTD Guarantee Issue Amount)

If you are only requesting insurance up to the Guarantee Issue Amount, then:

- $700 is the Maximum Weekly Benefit you enter in Step D for STD
- $3,000 is the Maximum Monthly Benefit you enter in Step L for LTD

If your annual income is greater than $60,000, you have the opportunity to apply for insurance in excess of the Guarantee Issue Amount. You apply for this additional insurance by completing the Group Disability Evidence of Insurability Form that follows, and submitting it with this request form.

If you will be applying for insurance in excess of the Guarantee Issue Amount and will be submitting the evidence of insurability form, then:

- $1,400 is the Maximum Weekly Benefit you enter in Step D for STD
- $6,000 is the Maximum Monthly Benefit you enter in Step L for LTD

SECTION 5: BENEFIT AMOUNT AND INITIAL PREMIUM PAYMENT CALCULATION (CONTINUED)

Determining the Billing Frequency (Step "R") – To pay premium every 3 months (Quarterly), insert a 3. To pay premium twice a year (Semi-Annually), insert a 6. To pay premium once a year (Annually), insert a 12.

If you are also eligible for and electing continuation of group term life insurance under the portability provision, the billing frequency must be the same on both requests.

SECTION 6: ELIGIBILITY CONDITIONS

To be eligible for insurance, you must be able to satisfy all of the conditions listed in Section 6.

SECTION 8: ACKNOWLEDGEMENT AND SIGNATURE

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section, and allows the form to be processed by Mutual of Omaha.

SECTION 9: INSTRUCTIONS

Follow these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form, the evidence of insurability form (if applicable) and your initial premium payment to Mutual of Omaha as soon as possible after your insurance ends under the group plan.

Remember, to be considered for insurance under the disability continuation plan(s), your request must be received within 31 days of the date insurance under the group plan ended.

Benefits Summary

	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable.	
	STD benefits begin 30 days after the onset of your disabling injury or illness.	LTD benefits begin 180 days after the onset of your disabling injury or illness.
Benefit Amount	60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount (less other income sources).	60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount (less other income sources).
Maximum Benefit Amount	▪ $700 per week guarantee issue ▪ $1,400 per week with approved evidence of insurability	▪ $3,000 per month guarantee issue ▪ $6,000 per month with approved evidence of insurability
Maximum Benefit Period	Benefits are available for up to 21 weeks (following the elimination period).	If you become disabled prior to age 60, benefits are payable to age 65. At age 60 (and older), the benefit period will be based on a reduced duration schedule.
Survivor Benefit	If you pass away while receiving benefits, your benefits will be provided to your eligible survivors for a period of time after your death.	
Alcohol and Drug Abuse Benefits	NA	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
Mental Disorder Benefits	NA	For disabilities related to mental disorders, benefits are available for up to 24 months.

MUTUAL of OMAHA
Begin today.

Group Disability Continuation Request Form

Premium Services
Underwritten by: United of Omaha Life Insurance Company

Please refer to "A Guide for Successfully Completing the Group Disability Continuation Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

Section 1: Group and Employee Eligibility Information (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name*	**Group ID Number***
	G000 __ __ __ __

Coverage(s) Eligible for Continuation*†	**Annual Salary***	**Last Monthly Premium Amount*‡**
☐ Short-Term Disability (STD) ☐ Long-Term Disability (LTD)	$	$

Date of Hire (MM/DD/YYYY)*	**Initial Coverage Effective Date** (MM/DD/YYYY)*
	STD (if applicable) _____ LTD (if applicable) _____

Last Day Worked (MM/DD/YYYY)*	**Date of Status Change/Termination/Layoff** (MM/DD/YYYY)*

†*A coverage is only eligible for continuation if the group policy for the specific coverage contained a continuation provision rider (either Portability or Conversion).*
‡*Provide the last monthly premium amount remitted to Mutual of Omaha for the employee's coverage (available on the employer's last billing statement, if list-billed).*

Section 2: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*	**First Name***	**MI**

Street Address*	**E-mail Address**

City*	**State***	**Zip Code***	**Telephone***

Birth Date (MM/DD/YYYY)*†	**Social Security Number***	**Gender***
		☐ Female ☐ Male

†*The applicant must be age 69 or less to be eligible for insurance.*

Consent to E-mail Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via e-mail.

Reason for Request*

Please indicate why you are requesting continued disability insurance:
☐ Status Change/Reduction in Hours ☐ Employment Ended/Terminated ☐ Involuntary Layoff

Section 3: Continuation Insurance Election

Type of Insurance Requested†

☐ STD Only ☐ LTD Only ☐ Both STD and LTD

†*Insurance is only eligible for continuation if the group policy for that specific insurance contained a continuation provision rider (either Portability or Conversion).*

Section 4: Monthly Rates

Age	**0 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60+**
STD Rates Per $10 of Weekly Benefit	$0.946	$1.123	$1.361	$1.560	$1.981	$2.548
LTD Rates Per $100 of Monthly Benefit	$1.680	$2.413	$3.317	$4.273	$4.643	$5.113

Section 5: Benefit Amount and Initial Premium Payment Calculation

STD (Complete if applicable)		**LTD** (Complete if applicable)	
A. Enter your annual salary.	$	I. Enter your annual salary.	$
B. Multiply "A" times 60% (the benefit percentage).	$	J. Multiply "I" times 60% (the benefit percentage).	$
C. Divide "B" by 52.	$	K. Divide "I" by 12.	$
D. Enter the Maximum Weekly Benefit.	$	L. Enter the Maximum Monthly Benefit.	$
E. Enter the lesser of "C" or "D". This is your STD Weekly Benefit Amount.	$	M. Enter the lesser of "K" or "M". This is your LTD Monthly Benefit Amount.	$
F. Divide "E" by 10.	$	N. Divide "M" by 100.	$
G. Enter the STD rate for your age from Section 4.	$	O. Enter the LTD rate for your age from Section 4.	$
H. Multiply "F" times "G".	$	P. Multiply "N" times "O".	$
		Q. Add "H" and "P" together, as applicable.	$
		R. Enter the billing frequency – 3 for Quarterly, 6 for Semi-Annual or 12 for Annual.	
		S. Multiply "Q" times "R". This is your **Initial Premium Payment**.	$

Section 6: Eligibility Conditions

To be eligible for disability continuation insurance, you satisfy all of the following conditions:

- You must be age 69 or less;
- You must not be disabled;
- You must not be retired;
- You must not be on a leave of absence from the employer (named in Section 1);
- You must not be unable to work for the employer (named in Section 1) due to a labor strike;
- You cannot be covered under any similar individual or group disability insurance plan or policy; and
- You must have been insured under the group disability plan offered by the employer (named in Section 1), and the plan it replaced (if applicable), for at least twelve consecutive months immediately prior to the date your eligibility for insurance under the group plan ended.

Section 7: 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 subjects such person to criminal and civil penalties.

Section 8: Acknowledgement and Signature

I understand that I may request insurance under the continuation plan(s) subject to the following:

- I understand that the insurance available through disability continuation is subject to the rules of the policy governing each continuation plan (STD and/or LTD).
- I understand that I must satisfy the plan's requirements to be eligible for benefits, including the eligibility conditions outlined in Section 6 above, and that payment of premium does not ensure my eligibility for insurance. In the event that any premium is collected after eligibility for continued insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing each continuation plan (STD or LTD).
- This request for insurance must be received by Mutual of Omaha within 31 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha. I understand that any insurance applied for in excess of the Guarantee Issue Amount is not effective until my application is approved by Mutual of Omaha.
- Premium amounts may increase as I enter a higher premium age category, or if continuation plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT _____ **DATE** _____/_____/_____

Section 9: Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased under the group plan. The form and payment must be received by Mutual of Omaha within 31 days of the date insurance under the group plan ended.
2) If you are requesting a benefit amount in excess of the Guarantee Issue Amount ($700 of weekly benefit for STD or $3,000 of monthly benefit for LTD), a completed and signed Group Disability Evidence of Insurability Form must include your submission for the extra insurance to be considered.
3) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.
4) Submit this form, the evidence of insurability application (if applicable) and payment to:
   Mutual of Omaha
   Policyowner Services
   PO BOX 2147
   Omaha NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha toll-free at (877) 466-8367.

A Guide for Successfully Completing the Group Disability Insurance Evidence of Insurability Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. So that we can effectively determine if you qualify for group disability insurance (whether you are seeking new coverage or additional coverage), we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

Submission Options

For your convenience, there are a couple of ways in which you can complete and submit the form:

- Recommended – An electronic version can be completed online at *www.mutualofomaha.com/eoi*
- A "fillable" PDF version is available online at *www.mutualofomaha.com/module/gforms.phtml*. This version allows you to type information into the form (to ensure responses are fully legible), then print, sign and mail the form.

Important Tips for Paper Copy Submission

- All sections of the form are to be completed by the employee. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting to Mutual of Omaha.

Guidelines for Section 1: Employer Information

The Group ID Number for your employer will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.

Guidelines for Section 2: Employee Contact & Employment Information

Employment information is for your current employer (identified in Section 1) and your current job.

To ensure any additional correspondence regarding your form occurs as quickly as possible, check the box to consent to receive future correspondence via e-mail.

Guidelines for Section 3: Employee Personal Information

All fields in this section are required.

Be sure to provide weight in pounds, and height in feet and inches.

Guidelines for Section 4: Requested Coverage

Indicate the type of insurance you are applying for, whether short-term disability, long-term disability or both.

Guidelines for Section 5: Health Information

The health information provided in this section is used to underwrite your application for insurance.

Be sure to answer all questions as honestly and accurately as possible, and provide additional information where indicated.

For Degree of Recovery, indicate the percent of function you have recovered. (100% indicates full recovery. Any lesser percentage would be a judgment of partial recovery.)

Guidelines for Section 7: Authorization to Disclose Personal Information & Application for Insurance

Please read this section in its entirety. By signing, you are applying for life insurance coverage with Mutual of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of underwriting your application.

If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.

To be complete, the form must be signed by you.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, Mutual of Omaha and its affiliated companies ("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. 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 – ATTN: GROUP UNDERWRITING INDIVIDUAL SELECTION; MUTUAL OF OMAHA; MUTUAL OF OMAHA PLAZA; OMAHA, NE 68175.

MIB GROUP, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha and its affiliated companies, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is – 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

Mutual of Omaha and its affiliated companies, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

Mutual of Omaha and its affiliated companies, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address – Attn: Group Underwriting Individual Selection; Mutual of Omaha; Mutual of Omaha Plaza; Omaha, NE 68175.

INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha and its affiliated companies ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation.

You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it.

We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

Section 5 Cont'd: Health Information (Please print clearly. A response is required for each health question.)

Health Question 4	**Response***
Have you been absent from work for more than five consecutive working days because of illness or injury during the past five years?	☐ YES ☐ NO
Health Question 5	**Response***
Within the past six months, have you been prescribed medication by a medical professional or taken any medication requiring a prescription?	☐ YES ☐ NO
Health Question 6	**Response***
During the past seven years, have you regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	☐ YES ☐ NO
Health Question 7	**Response***
If female, are you pregnant? If YES, please provide anticipated delivery date (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	☐ YES ☐ NO

Part B – If you responded YES questions 1, 2, 3 or 4 above, you must complete the following, as applicable:

Ques. #	Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam	Date of Occurrence (MM/DD/YYYY)	Duration (WEEKS, MONTHS OR YEARS)	Degree of Recovery (% OF FUNCTION)

Part C – If you responded YES to question 5 above, you must complete the following, as applicable:

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

Section 6: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

- **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 subjects such person to criminal and civil penalties.
- **Arkansas/Kentucky/Louisiana/New Mexico/Ohio/ Tennessee:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- **Georgia/Oregon:** 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 may be crime and may subject such person to criminal and civil penalties.
- **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.
- **Pennsylvania:** 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 subjects such person to criminal and civil penalties.
- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

Section 6 Cont'd: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

- **Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- **Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Section 7: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 7

MIB Group, Inc. (MIB) means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.

Personal Information means information about me, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

Part B – Authorization to Receive and Disclose Personal Information

To the MIB: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information about me to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to the MIB. I understand that the Personal Information received by the MIB 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.

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

Name(s) used for medical records (if different than the name provided on the form): _____

_____

Part C – Application for Insurance

I apply for disability insurance for me. I understand that any insurance in excess of the guaranteed issue amount will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approve the amount. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until my certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha request additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

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

I will retain a copy of this form with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE _____ DATE __ __/__ __/__ __ __ __

Section 8: Form Submission

To help ensure efficient processing, include this form with your disability continuation request submission, or mail this completed form to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS