

## **Disability Income Application Instructions**

Just print/fill out the application by hand as best you can. On any dates for health history, you only need a month/year and do not need the exact date.

**Please fax it to us Toll Free at (877) 718-8056 using this cover page or if you prefer, you may scan/email it back to your agent using his/her email address. Your agent will call you shortly after the application arrives.**

**Please DO NOT mail the application to the address on the forms.**

**Enter Your Agent's Name: \_\_\_\_\_**

You only need to fax or scan/email the application back to us. We do not need the original.

If you have any questions or need help in any way, please call us Toll Free at (866) 270-6209 and ask for your agent.

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By



## Application For:

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

ACCIDENT ONLY DISABILITY INSURANCE

### SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

#### PROPOSED INSURED INFORMATION

<p><b>1.</b> Proposed Insured's Name (First, Middle, Last) _____</p> <p><b>2.</b> Sex <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p><b>3.</b> Age _____ DOB ____/____/____</p> <p><b>4.</b> Birth State _____</p> <p><b>5.</b> Social Security Number _____</p> <p><b>6.</b> Height (Ft &amp; In) _____ Weight (Lbs) _____</p> <p><b>7.</b> Home Tel. Number ( _____ ) _____        Daytime Tel. Number ( _____ ) _____        Best Time to Call _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p> <p><b>8.</b> Legal Residence Address (Number, Street, City, State, Zip) _____</p> <p><b>9.</b> Mailing Address for Premium Notices (if different than above) _____</p> <p><b>10.</b> E-Mail Address (optional) _____</p> <p><b>11.</b> Citizenship Status (check one):  <input type="checkbox"/> U.S. Citizen, or  <input type="checkbox"/> Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years.        If checked, please complete Foreign Travel Questionnaire.  <input type="checkbox"/> Other (Please explain) _____</p>	<p><b>12.</b> Employer _____        Address _____        Business Phone Number _____        Occupation _____        List exact duties _____</p> <p><b>13.</b> Are you actively working at least 30 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>14.</b> How long have you been employed in your current position?        _____ Years _____ Months</p> <p><b>15.</b> Proposed Insured's Employment Status:  <input type="checkbox"/> Employee (No Ownership)  <input type="checkbox"/> Sole Proprietor  <input type="checkbox"/> Partner in Partnership _____ % Ownership  <input type="checkbox"/> Shareholder in Sub "S" Corp. _____ % Ownership  <input type="checkbox"/> Owner of C - Corp. _____ % Ownership</p> <p><b>16.</b> Do you have any part-time or off-season occupation?  <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," list exact duties/hours per week) _____</p> <p><b>17.</b> Are you a member of an approved Association Group or Franchise?  <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," full name of organization _____        Date joined (Mo./Yr.) _____</p> <p><b>18.</b> Full name of beneficiary _____        Relationship to Proposed Insured _____</p>
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#### OTHER COVERAGE AND REPLACEMENT INFORMATION

**1.** Are you covered under or eligible for: (Check all that apply)

The Federal Employee's Compensation Act (FERS or CSRS)? .....  Yes  No

The Railroad Retirement Act? .....  Yes  No

Workers Compensation? .....  Yes  No

**2.** Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance? ...  Yes  No

If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3. Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.**

I am requesting termination of my Policy No. \_\_\_\_\_ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

**INCOME INFORMATION**

<b>1. Income information</b> (Attach financial records if required. See underwriting guide for details)	<b>Current Year</b>	<b>Prior Year</b>
(a) Gross Annual Earned Income .....	\$ _____	\$ _____
(b) If <b>self employed</b> , 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.) .....	\$ _____	\$ _____
<b>Total</b> .....	\$ _____	\$ _____

**2. During the last 12 months 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," monthly average over last 12 months ..... \$ \_\_\_\_\_

**SECTION B Complete only if applying for Accident Only Disability Insurance**

- |   |   |
|---|---|
| <p><b>1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs</b> (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>(If "Yes," submit a Drug or Alcohol Use Questionnaire)</p> <p><b>2. 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, sky diving, hang gliding, skin or scuba diving?</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>(If "Yes," submit an Avocation Questionnaire)</p> | <p><b>3. Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider</b> (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If "Yes," give details below. (Attach a separate signed sheet if necessary.)</p> |
|---|---|

Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION C PLAN INFORMATION**

**ACCIDENT ONLY DISABILITY INSURANCE**

**Monthly Benefit Amount** \$ \_\_\_\_\_

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

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

**Optional Riders:**

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

Accident Medical Expense Rider

Maximum Benefit:  \$1,000  \$2,000  \$3,000  \$5,000

**SECTION D****PREMIUM COLLECTION****Billing Options:**

1. No Cash With App (Effective Date = Issue Date)

BSP

2. Cash With App (Effective Date = Application Date)

Initial Premium Collected \$ \_\_\_\_\_ Renewal Premium \$ \_\_\_\_\_

BSP (If BSP is selected, collect 2 months of premium.)

Quarterly

Semiannual

Annual

3. Payroll Deduction (only available with Accident Only plan)

Add to Existing PRD – Group Number..... \_\_\_\_\_

First Deduction Date ..... \_\_\_\_\_

Number of Deductions ..... \_\_\_\_\_

Effective Date ..... \_\_\_\_\_

**SECTION E****Complete only if Billing Mode is BSP****AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")**

I authorize Mutual of Omaha to withdraw funds from my account for my initial and/or renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

1. Specify the date the premiums will be withdrawn:  1st of the Month or  15th of the Month

2. Attach your check from the account from which premiums will be withdrawn or provide routing and account number.

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

**AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION**

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, consumer reporting agencies and any other organization, institution, or person that has records or knowledge of me or my health to release personal information about me to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Personal information includes my health information such as medical history, mental or physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may include my entire medical record.

The Personal information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my 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.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy. I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

**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 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 Insurance Company may require: medical records, an underwriting assessment, a medical examination, or other information.
3. Applicant agrees that Mutual of Omaha Insurance Company 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 Insurance Company, (b) Mutual of Omaha Insurance Company 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 Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company 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 of the 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 Insurance Company (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

**SECTION F**

**PLEASE READ AND SIGN - continued**

**I have (a) read and understand the Authorization to Disclose Personal Information and Agreement Section; (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 Printed Name of Payor Date  
(if Billing Mode is BSP and Payor is other than Proposed Insured)

**I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . .  Yes  No**

(If "No," please explain.) \_\_\_\_\_

I conducted said interview in person  Yes  No

(If "No," please explain.) \_\_\_\_\_

Signature of Producer Producer's Printed Name Date

Office Name Office Address

Signature of Producer Producer's Printed Name Date

Office Name Office Address

**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 Redislosure**

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**

Meanings of Terms

"MIB Group, Inc. (MIB)" 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 the MIB:

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 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.

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):

Blank lines for name(s) used for medical records.

Signature of Proposed Insured

Date

Signature of Spouse (If Proposed Insured)

Date

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

Date

**Agent/Producer Statement**

- 1 Do you have any reason to believe the policy applied for has replaced or will replace any existing disability income insurance? (If "Yes," fulfill all state requirements.).....  Yes  No
- 2 Has a medical examination of the Proposed Insured been scheduled?.....  Yes  No  
If "Yes," when? \_\_\_\_\_ By \_\_\_\_\_
- 3 Has the client profile interview been completed? .....  Yes  No  
If "No," the client profile interview has been scheduled for \_\_\_\_\_ and \_\_\_\_\_  
Date Time (Please circle -Eastern, Central, Mountain or Pacific)
- 4 Did you give the Notice of Information Practices to the Proposed Insured?.....  Yes  No  
Date \_\_\_\_\_  
Mo. Day Yr. \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_ Agent/Producer's Signature \_\_\_\_\_

**Agent/Producer Information:**

Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____
Agent/Producer Name _____	Agent/Producer Social Security Number _____
Comm. % Share _____	Agent/Producer Phone Number (_____) _____ Area Code
Agent/Producer E-mail Address _____	
Agent/Producer's Stamp _____	Agent/Producer's License/ID Number _____