Mutual *of* Omaha Insurance Company

APPLICATION for INDIVIDUAL DISABILITY INCOME

TEXAS

Mutual *of* Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

INDIVIDUAL DISABILITY INCOME
Application Submission Checklist

☐ **Application**

1. Must be taken during an in-person interview.
2. Answer all questions completely.
3. Be sure to leave all applicable forms with the proposed insured.
4. Sign and Date in all places indicated.
5. See reverse side of this page for detailed information.

☐ **Privacy Authorizations**

The HIPAA and MIB authorizations are to be signed and returned with the application.

☐ **Collect Premium Amount**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected. For BSP collect two months premium.

☐ **Attach Copy of Quote (if available)**

☐ **Complete Oral Fluid Test (not applicable in all states) or Schedule Paramed Exam as Applicable**

APPS 1-800-635-1677 PORTAMEDIC 1-800-765-1010

☐ **Initiate the Client Profile process with the Proposed Insured**
Call 1-800-462-2322

☐ **Indicate Underwriting Requirements Initiated or Completed**

- ☐ Client Profile Interview
- ☐ Blood Profile
- ☐ Physical Data
- ☐ Oral Fluid Test
- ☐ (Not applicable in all states)
- ☐ Long Form
- ☐ MD Exam
- ☐ EKG
- ☐ Mammogram
- ☐ Urinalysis

☐ **Indicate Financial Requirements Completed**

Proof of Income (Full Federal Tax Return and all Schedules and/or W2 form) is needed if:

- ☐ Self-Employed
- ☐ Monthly Benefit is more than $3,000 for salaried applicants (includes issued and pending coverage from all sources)

☐ **Any Additional Information or Comments**

_____

_____

_____

NOTE: BROKERAGE ONLY – Please list your "commission code" in the box on the first page of the application. This will help avoid delay in commission payment.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

There are two sections to this application: One section is the general application. The other section includes necessary administrative forms that you will need at time of sale.

Part 1: APPLICATION

- Notify the applicant that a telephone interview will be conducted to obtain additional information and/or to verify application information.

Section A: General Questions

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.

Section B: Underwriting Information

- Complete all information in full and provide details in the area provided.

Section C: Income Information

- Complete all information in full and provide details in the area provided.

Section D: Plan Information

- The total premium amount must be listed within each section. The total amount collected must equal the total amount of all Policy Premiums + all Rider Premiums.
- Show the amount collected, modes (annual/semi-annual/quarterly/Individual BSP), and amount of renewal premium. Collect two months for Bank Service Plan (BSP).
- If PRD mode, complete the PRD Authorization form.

Section E: Other Coverage Information

- All details of other coverages (inforce or being applied for) must be listed.

Section F: Agreements

- The X indicates where the applicant(s) signature is needed.
- Please request the applicant read the entire Agreement section before signing.
- Any alterations to this section will not be accepted.

Part 2: ADMINISTRATIVE FORMS

Privacy Authorizations Appendix 1 and 2)

- The HIPAA and MIB authorizations are to be signed and returned with the application.

Agent/Producer Statement (Appendix 3)

- This is necessary information for the underwriting process.
- Until further notice only agency commissions can be split.

Notice of Information Gathering Practices, MIB Group, Inc. Pre-Notice (Appendix 4, 5 & 6)

- Remove notice and provide to proposed insured at time of application. The Notice of Information Practices informs the Proposed Insured that Mutual of Omaha may obtain information about the Proposed Insured from other sources. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's rights to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act.

Receipt and/or Temporary Health and Accident Insurance Agreement

- Detach and leave with proposed insured.

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Replacement Notice – complete if applicable

- Complete and leave a copy with applicant (if applicable).

HIV Consent Form – complete if applicable

- Form must be signed and dated. Detach 1st copy and leave with Proposed Insured.

Drug, Alcohol Usage, Avocation Questionaires

- Complete all information in full, sign and date.

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By
0324050		

Application For:

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

- ☐ Accident Only Disability Insurance
- ☐ Short-Term Disability Insurance
- ☐ Long-Term Disability Insurance
- ☐ Business Operating Expense Disability Insurance

SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES

Proposed Insured Information

1. Proposed Insured's Name (First, Middle, Last)
_____

2. Sex ☐ Female ☐ Male

3. Age _____ DOB _____/_____/_____

4. Birth State _____

5. Height (Ft & In) _____ Weight (Lbs) _____

6. Home Tel. Number (_____) _____
Daytime Tel. Number (_____) _____
Best Time to Call _____ ☐ A.M. ☐ P.M.

7. Legal Residence Address (Number, Street, City, State, Zip)
_____
_____

8. E-Mail Address (optional)_____

9. Mailing Address for Premium Notices (Number, Street, City, State, Zip) _____
_____

10. Full name of beneficiary _____
Relationship to Proposed Insured_____

11. Social Security Number _____-_____-_____

12. Drivers License Number _____

13. Are you a citizen of the United States?..... ☐ Yes ☐ No
If "No," please include your Permanent Resident Card form I-551 (also known as an "Alien registration Receipt Card" or "Green Card") number _____
and Visa Type_____

If not a citizen of the United States, have you resided in the United States at least 3 consecutive years?..... ☐ Yes ☐ No

14. Employer_____
Address_____
Business Phone Number_____
Occupation _____
List exact duties. _____
_____

15. How long have you been employed in your current position?
_____Years _____Months

16. Proposed Insured's Employment Status:
- ☐ Employee (No Ownership)
- ☐ Sole Proprietor
- ☐ Partner in Partnership ___ % Ownership
- ☐ Shareholder in Sub "S" Corp. ___ % Ownership
- ☐ Owner of C – Corp. ___ % Ownership

Number of Full-time Employees ____
Do you have any part-time or off-season occupation?
☐ Yes ☐ No (If "Yes," describe duties.)_____
_____

17. Are you a member of an Association Group or Franchise?
☐ Yes ☐ No If "Yes," full name of organization. _____
_____
Date joined (Mo./Yr.)_____

Other Coverage and Replacement Information

1. Are you covered under or eligible for the Federal Employee's Compensation Act (FERS or CSRS) or the Railroad Retirement Act?..... ☐ 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?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

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

Income Information

1. Income information (Attach financial records if required. See underwriting guide for details)	Current Year	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 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," average over last 12 months $ _____

SECTION B Complete only if applying for Accident Only Disability Insurance

1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine 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.)

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? ☐ Yes ☐ No
(If "Yes," submit an Avocation Questionnaire.)

3. During the last 3 years, have you had your drivers license suspended or revoked? ☐ Yes ☐ No
If "Yes," please provide details. _____

4. During the last 3 years, have you received or been advised by a healthcare provider (including chiropractor) to have treatment for any injury, impairment or disability? ☐ Yes ☐ No
If "Yes," give details below. (Attach a separate signed sheet if necessary.)

Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

SECTION C Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.

1. During the last 10 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 9.

- ☐ Kidney or Urinary Tract
- ☐ Cancer or Tumor
- ☐ Heart or Coronary Arteries
- ☐ Alcohol or Drug Abuse
- ☐ Liver or Hepatitis
- ☐ Stroke or Cerebral Vascular condition
- ☐ Diabetes or Glandular condition
- ☐ Psychological, Emotional or Psychiatric condition
- ☐ Upper or Lower Digestive Tract
- ☐ Spine, Neck or Back
- ☐ High Blood Pressure, Arteries or Veins
- ☐ Arthritis or Joints (including replacements)
- ☐ Anemia or Blood
- ☐ Lung or Breathing Problem
- ☐ Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy)
- ☐ Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)
- ☐ Chronic Fatigue Syndrome
- ☐ Skin or Connective Tissue
- ☐ Fibromyalgia or Myalgia
- ☐ Epstein-Barr Viral Infection
- ☐ **None of These**

SECTION C Complete only if applying for SHORT-TERM DISABILITY, LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance. - continued

2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? ..... ☐ Yes ☐ No

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 (copy from pharmacy label, if applicable)
Dosage/Frequency
Date
Reason
Prescribing Physician (if applicable)
Phone Number (if applicable)

4. 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

5. 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.)

6. Have you:
(a) 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. _____
_____
(b) ever applied for or received disability benefits of any kind? ..... ☐ Yes ☐ No
If "Yes," provide details. _____
_____

7. Are you pregnant? ..... ☐ Yes ☐ No

8. Other than previously answered, during the last 10 years have you (a) been advised to have any medical test or surgical operation that was not performed, or (b) had any medical test or surgical operation performed, or (c) gone to a hospital, doctors' office (including chiropractic), clinic, dispensary or sanatorium for observation, examination or treatment? ..... ☐ Yes ☐ No

9. Complete this section to expand on questions 1 and 8 in Section C. (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	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

SECTION D Complete only if applying for BUSINESS OPERATING 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.)

Average Monthly Expenses:

No. of employees		Water	$
Employees' salaries	$	Telephone	$
Interest on loans	$	Postage and stationery	$
Mortgage interest payments	$	Equipment rental	$
Insurance (casualty/liability)	$	Laundry	$
Property taxes (real and personal)	$	Other fixed operating expenses (please itemize)	
Depreciation (office equipment only)	$		$
Rent (including land rental)	$		$
Electricity	$		
Heat	$	Total Monthly Expenses	$

SECTION E PLAN INFORMATION

Accident Only Disability Insurance

Monthly Benefit Amount $_____

Elimination Period: ☐ 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

Short-Term Disability Insurance

Monthly Benefit Amount $_____

Elimination Period Accident/Sickness: ☐ 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 (check one option) ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

If applying for Critical Illness Benefits Rider, complete additional health question below:
Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. ..... ☐ Yes ☐ No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

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 (check one option)
☐ $125 ☐ $250 ☐ $350 ☐ $500

☐ Critical Illness Benefits Rider (check one option)
☐ $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

If applying for Critical Illness Benefits Rider, complete additional health question below:
Have your natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60 **with any of the conditions** from the following list? Diabetes, heart disease, stroke, kidney disease or cancer (other than non-melanoma skin cancer)? If "Yes," please give detail below. ☐ Yes ☐ No

Family Member/Relationship	Diagnosis	Age at Time of Diagnosis

Business Operating 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 F PREMIUM COLLECTION

Amount Collected $ _____ Initial Premium $_____ Renewal Premium $ _____

Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

☐ Bank Service Plan (BSP) - Complete "Authorization to Withdraw Funds" (If BSP is selected, collect 2 months of premium.)

☐ Payroll Deduction

Add to Existing PRD – Group Number ..... _____

First Deduction Date ..... _____

Number of Deductions ..... _____

Effective Date of Payroll Deduction ..... _____

SECTION G Complete only if Billing Mode is BSP

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")

As a convenience to me, 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.

SECTION H PLEASE READ AND SIGN

AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. ("MIB") – The MIB Group, Inc. ("MIB") is a non-profit membership organization of life insurance companies which 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, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to Mutual of Omaha Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize Mutual of Omaha Insurance Company and its reinsurers to disclose Personal Information about me 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 submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

AGREEMENT – I, the undersigned, agree that (a) all answers in this application are true and complete (b) Mutual of Omaha Insurance Company will rely upon these answers to determine insurability, and (c) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application (or on the first premium deduction date), and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the date of the policy will be the date of the application or the expiration of any replaced coverage, if later. I agree no temporary or interim insurance of any kind will be in effect, except as may be provided in any Conditional Receipt.

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, I must complete all required examinations and tests (medical, paramedical, laboratory), and Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests and any other information (such as an Attending Physician's Statement) that is requested by Mutual of Omaha Insurance Company to underwrite the application. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date.

No Agent/Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

SECTION H — PLEASE READ AND SIGN - continued

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.

Notice to Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee Residents Only: 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.

Notice to Colorado Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Notice to District of Columbia/Pennsylvania Residents Only: 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.

Notice to Florida Residents Only: 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.

Notice to Kansas Residents Only: 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 as determined by a court of law.

Notice to New Jersey Residents Only: Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

Notice to Oregon Residents Only: 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.

Notice to Puerto Rico Residents Only: 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.

Notice to Tennessee Residents Only: 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.

Notice to Vermont Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Notice to Virginia Residents Only: Must include "may have violated state law" in the fraud statement. Therefore, use this fraud warning statement: 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.

I have (a) read and understand the Agreement and Fraud Warning Section and any Receipt provided; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

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

I/We certify that during an in-person 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.)_____

Signature of Producer	Producer's Printed Name	Date
	C.M. Crowston	

Office Name	Office Address
All Aboard Benefits	6162 E. Mockingbird Ln. Ste.104 Dallas,TX 75214

Signature of Producer	Producer's Printed Name	Date

Office Name	Office Address

Appendix 1 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, Exclusive Healthcare, Inc., 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

Appendix 2 Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

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): _____

_____

_____

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Spouse (If Proposed Insured) Date

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

Appendix 3 — 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 _____ (Date) and _____ (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 C.M. Crowston

Agent/Producer Social Security Number _____

Comm. % Share _____

Agent/Producer Phone Number (214) 821-6677 (Area Code)

Agent/Producer E-mail Address mike@allaboardbenefits.net

Agent/Producer's Stamp 0324050

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 _____

Appendix 4 — 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. 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.

Appendix 5 — Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice

The information regarding your insurability will be treated as confidential.

However, the Company or its reinsurers may make a brief report to the MIB Group, Inc. (MIB), a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply for life and health insurance to another company which is also a member of MIB or if a claim for benefits is submitted to such a company, MIB will, upon request, supply the information in its file to that company.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the 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 office is P.O. Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.

In compliance with applicable law, the 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.

Appendix 6 — Mutual of Omaha Insurance Company
Investigative Consumer Reports Notice

Mutual of Omaha Insurance Company ("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.

Remove Notices and Give to Proposed Insured

Conditional Receipt

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

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

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

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

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

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

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

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

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

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

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

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

Date: _____ Signed at: _____
City State

_____
Signature of Proposed Insured

_____ _____
Signature of Producer Signature of Producer

Conditional Receipt

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

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

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

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

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

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

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

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

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

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

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

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

Date: _____ Signed at: _____
City State

_____
Signature of Proposed Insured

_____ _____
Signature of Producer Signature of Producer

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on_____.
Date

_____
Applicant's Signature

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is to your advantage to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on_____.
Date

_____
Applicant's Signature

Notice and Consent for HIV-Related Testing

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine 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 three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

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. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

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 result 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.

Notice and Consent for HIV-Related Testing

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
☐ ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

Notification of Test Resultw

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. 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 possible positive test result _____

Address _____

In the event that the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test result as described above. I have read the information on this form about what a test result means.

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.

_____
Signature of Proposed Insured or Parent/Guardian

_____
Date Signed

_____
Name of Proposed Insured

_____
Address

Notice and Consent for HIV-Related Testing

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
☐ ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

Notification of Test Resultw

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. 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 possible positive test result _____

Address _____

In the event that the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test result as described above. I have read the information on this form about what a test result means.

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.

_____
Signature of Proposed Insured or Parent/Guardian

_____
Date Signed

_____
Name of Proposed Insured

_____
Address

Drug Usage Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

1. Name of Proposed Insured _____ Date of Birth_____
Please Print

2A. Are you now using or have you used during the last 10 years any of the following drugs:

	Yes	No
(a) Opium derivatives: Heroin, Morphine, Demerol, Methadone, Codeine, Percodan, Dilaudid	☐	☐
(b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital	☐	☐
(c) Marijuana: Hashish, Cannabis	☐	☐
(d) Amphetamines: Benzedrine, Dexedrine, Methedrine, Preludin	☐	☐
(e) Cocaine, Crack	☐	☐
(f) Hallucinogens: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP	☐	☐
(g) Sedatives and Tranquilizers: Librium, Valium, Quaalude, Dalmane, Placidyl	☐	☐

2B. Were any of the above prescribed by a physician? ☐ Yes ☐ No If "Yes," which? _____

_____

3. If "Yes" answers in 2A or 2B, please give details.

Type	Usual Quantity	Frequency of Use	How Taken (Oral, Injection, Inhaled, Smoked, Etc.)	Date: From — To

4. Except those prescribed by a physician, are you now using or have you used during the last 10 years any other drugs not listed in number 2 or 3 above? ☐ Yes ☐ No If "Yes," explain _____

_____

5. Have you ever sought medical treatment because of drug usage? ☐ Yes ☐ No
If "Yes," state dates and names of doctors and institutions consulted. _____

_____

_____

6. Please indicate any additional relevant information. _____

_____

_____

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ the _____ day of_____ , _____

_____ _____
Witness Signature of Proposed Insured

Alcohol Use Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

Name of Proposed Insured _____ Date of Birth _____
Please Print

1. Do you presently use alcoholic beverages? ☐ Yes ☐ No If "No," date of last drink. _____
If "Yes," please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. Did you ever drink substantially more than at present? ☐ Yes ☐ No If "Yes," during what time period?

Dates: From _____ To _____
Please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Why did you change your drinking habits? _____

_____

3. Are you active in Alcoholics Anonymous or other recovery groups? ☐ Yes ☐ No How long? _____

4. Have you ever consulted a doctor or received treatment because of your alcohol use? ☐ Yes ☐ No

If "Yes," indicate name and address of any doctor, hospital or treatment center and dates of treatment. _____

_____

_____

5. Are you presently taking, or have you ever taken, Antabuse or any other medication to control your drinking?
☐ Yes ☐ No If "Yes," please indicate date last used and name of doctor who prescribed it. _____

_____

6. Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No If "Yes," give dates and driver's license number. _____

_____

7. Have you ever used any other drugs, except over-the-counter drugs or those prescribed by a physician?
☐ Yes ☐ No (If answered "Yes," please complete Drug Usage Questionnaire.)

8 Remarks _____

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ the _____ day of _____ , _____

_____ _____
Witness Signature of Proposed Insured

M25817

Avocation Questionnaire

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Attn: Individual Health Underwriting

Name of Proposed Insured _____ Date of Birth _____
Please Print

1. Type of Avocation:

- ☐ Motorcycle Racing
- ☐ Auto Racing
- ☐ Boat Racing
- ☐ Stunt Driving
- ☐ Aircraft Piloting
- ☐ Rodeo Activities
- ☐ Rock/Mountain Climbing
- ☐ Sky Diving
- ☐ Scuba Diving
- ☐ Other_____

2. How many times per year do you participate in this activity?_____

3. Do you plan to continue participating in this activity in the future? ☐ Yes ☐ No

---

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ the_____ day of _____ , _____

_____ _____
Signature of Witness Signature of Proposed Insured