Mutual of Omaha

MutualCare® Solutions

Application for Long-Term Care Insurance

TEXAS

Application Package Contains:

Required Forms to be Submitted					
Long-Term Care Personal Worksheet	Must complete, sign and submit with application. This worksheet helps determine whether a Long-Term Care policy is suitable.				
Application	1. Sections A-H must be answered in full. Notes: Any changes must be initialed. Check height/weight build chart to ensure client eligibility. If the applicant wishes to provide an alternate mailing address other than the legal residence address shown on the application, please contact the service office at 1-877-894-2478. 2. Choose to complete either Section I or J. 3. Sections K-L must be answered in full.				
Premium Information	Authorization to Disclose Personal Information (HIPAA)	Producer Statement	Replacement Notice *(if applicable)*	Acknowledgement of Nonduplication *(applicable for age 65 and older)*	Authorization for Release of Information to My Insurance Agent and/or Agency *(if applicable)*

Required Forms to be Left with Applicant(s)				
Replacement Notice *(if applicable)*	MIB, LLC Pre-Notice	Things You Should Know Before You Buy Long-Term Care Insurance	Long-Term Care Insurance Potential Rate Increase Disclosure Form	
Acknowledgement of Nonduplication *(applicable for age 65 and older)*		Authorization for Release of Information to My Insurance Agent and/or Agency *(if applicable)*		Outline of Coverage

Not Contained within this Application Package:

Required Forms to be Left with Applicant(s) that are Not Included within this Package	
LTC Shopper's Guide *(Not included within this package. Please provide in addition.)*	Guide to Medicare for People Age 65 and Older *(Not included within this package. If applicable, please provide in addition.)*

MAP622_TX_0623

Inform your client(s) that we will conduct a telephone interview or face to face interview. Provide them a copy of "***Preparing for the Personal Health Interview***" included as last page of this package.

Unanswered questions on the application or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If a ***question does not apply*** to your client, answer it as "No" or "None" rather than "N/A."

If the applicant answers "Yes" to any question in ***Section D***, he/she is ineligible for coverage.

If after review of our application and underwriting guide you are unable to determine how underwriting will handle a case, you may obtain additional guidance by calling 1-800-551-2059 or by sending an e-mail to ltcunderwriting@mutualofomaha.com. Please do not call or e-mail until you have reviewed both the application and our underwriting guide to learn how we will handle the specific condition(s). To discuss a potential client the underwriter will need to know the client's age, height and weight, tobacco status for the past two years, all medications, all health conditions, and whether or not the client has previously been declined for coverage, and if so, why.

May be beneficial to send include a copy of illustration with the application.

Submit the fully completed application, and applicable completed forms to:

For regular mail submission:	**For overnight submission:**
Long-Term Care Service Office	Long-Term Care Service Office
P.O. Box 64901	7805 Hudson Rd., Ste. 180
St. Paul, MN 55164-0901	Woodbury, MN 55125-1591

For Fax submission, you, the producer, must:

- Use the **maximum resolution** to ensure the readability of the application/forms;
- Fax to **1-888-539-4672** and verify that the correct fax number is dialed to protect the privacy of the information contained in the application/forms;
- **Retain the original application/forms** in a secured location for at least 90 days to ensure we get through the underwriting process and avoid any legibility issues. Do not also send a paper copy of a faxed application/forms.

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Long-Term Care Insurance Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this policy to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this policy. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

Applicant A

The premium for the coverage you're considering will be $_____ per month, or a total of $_____ per year.

Applicant B

The premium for the coverage you're considering will be $_____ per month, or a total of $_____ per year.

The premium quoted in this worksheet isn't guaranteed and may change during the underwriting process and in the future while this policy is in force.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

Guaranteed renewable - The company can increase your premiums on this policy in the future if it increases the premiums for all policies like yours in this state.

Premium Increase History

Mutual of Omaha Insurance Company has sold long-term care insurance since 1987 and has sold this policy form since 2013. The company has not increased its premiums on this policy, but has on similar policies in the last ten (10) years. There was a 30% or greater premium increase in 2022. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	National Rate History
LT50/NH50/NHA/LTA/HCA	1997 - 2004	18% overall rate increase 2015
LT50/NH50/NHA/LTA/HCA	1997 - 2004	10% overall rate increase 2016
LT50/NH50/NHA/LTA/HCA	1997 - 2004	30% overall rate increase 2022
LTC04I	2004 - 2015	19% overall rate increase 2013
LTC04I	2004 - 2015	2022 rate increase range: 0% - 38%
LTC04G	2004 - 2014	22% overall rate increase 2013 (for issues prior to 8/1/2007)
LTC04G	2004 - 2014	2022 rate increase range: 0% - 38%
LTC04I7	2006 - 2009	2022 rate increase range: 0% - 38%
LTC09M	2009 - Present	2022 rate increase range: 0% - 38%
ICC13-LTC13	2013 - Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

Questions About Your Income

You do not have to answer the questions that follow. They're intended to make sure you've thought about how you'll pay premiums and the cost of care your insurance doesn't cover. If you don't want to answer these questions, you should understand that the company might refuse to insure you.

Applicant A	Applicant B
1. What resources will you use to pay your premium? ☐ Current income from employment ☐ Current income from investments ☐ Other current income ☐ Savings ☐ Sell investments ☐ Sell other assets ☐ Money from my family ☐ Other _____	1. What resources will you use to pay your premium? ☐ Current income from employment ☐ Current income from investments ☐ Other current income ☐ Savings ☐ Sell investments ☐ Sell other assets ☐ Money from my family ☐ Other _____
If you'll be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than seven percent (7%) of your income.	
2. Could you afford to keep this policy if your spouse or partner dies first? ☐ Yes ☐ No ☐ Hadn't thought about it ☐ Don't know ☐ Doesn't apply	2. Could you afford to keep this policy if your spouse or partner dies first? ☐ Yes ☐ No ☐ Hadn't thought about it ☐ Don't know ☐ Doesn't apply
3. What would you do if the premiums went up, for example, by fifty percent (50%)? ☐ Pay the higher premium ☐ Call the company/producer ☐ Reduce benefits ☐ Drop the policy ☐ Don't know	3. What would you do if the premiums went up, for example, by fifty percent (50%)? ☐ Pay the higher premium ☐ Call the company/producer ☐ Reduce benefits ☐ Drop the policy ☐ Don't know
4. What is your household annual income from all sources? (Check one) ☐ Less than $10,000 ☐ $10,000-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$50,000 ☐ More than $50,000	4. What is your household annual income from all sources? (Check one) ☐ Less than $10,000 ☐ $10,000-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$50,000 ☐ More than $50,000
5. Do you expect your income to change over the next ten (10) years? (Check one) ☐ No ☐ Yes, expect increase ☐ Yes, expect decrease	5. Do you expect your income to change over the next ten (10) years? (Check one) ☐ No ☐ Yes, expect increase ☐ Yes, expect decrease
6. If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium? ☐ Yes ☐ No ☐ Don't know	6. If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium? ☐ Yes ☐ No ☐ Don't know
7. Will you buy inflation protection? (Check one) ☐ Yes ☐ No	7. Will you buy inflation protection? (Check one) ☐ Yes ☐ No
Inflation may increase the cost of long-term care in the future.	
If you don't buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount? ☐ From my income ☐ From savings ☐ From investments ☐ Sell other assets ☐ Money from my family ☐ Other	If you don't buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount? ☐ From my income ☐ From savings ☐ From investments ☐ Sell other assets ☐ Money from my family ☐ Other
The national average annual cost of nursing home care in 2021 was $113,530, but this figure varies across the country. In ten years the national average annual cost would be about $185,000 if costs increase five percent (5%) annually.	
8. What elimination period are you considering? Number of days _____ in elimination period Approximate cost of care for this period: $_____	8. What elimination period are you considering? Number of days _____ in elimination period Approximate cost of care for this period: $_____
(Multiply the number of days by the approximate daily cost of care.)	
9. How do you plan to pay for your care during the elimination period? (check all that apply) ☐ From my income ☐ From my savings/investments ☐ My family will pay	9. How do you plan to pay for your care during the elimination period? (check all that apply) ☐ From my income ☐ From my savings/investments ☐ My family will pay

ICC23-470484

Questions About Your Savings and Investments

Applicant A

1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)
   - ☐ Less than $20,000
   - ☐ $20,000-$30,000
   - ☐ $30,001-$50,000
   - ☐ More than $50,000
2. Do you expect the value of your assets to change over the next 10 years? (Check one)
   - ☐ No
   - ☐ Yes, expect increase
   - ☐ Yes, expect decrease

Applicant B

1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)
   - ☐ Less than $20,000
   - ☐ $20,000-$30,000
   - ☐ $30,001-$50,000
   - ☐ More than $50,000
2. Do you expect the value of your assets to change over the next 10 years? (Check one)
   - ☐ No
   - ☐ Yes, expect increase
   - ☐ Yes, expect decrease

If you are buying this policy to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

☐ **◀ THIS BOX MUST BE CHECKED**
I agree that the company and/or its producer (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet.

X _____ _____
Signature of Applicant A — Date

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

☐ **◀ THIS BOX MUST BE CHECKED**
I agree that the company and/or its producer (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet.

X _____ _____
Signature of Applicant B — Date

I explained to the applicant(s) the importance of answering these questions.

_____
Printed Name of Producer

X _____ _____
Signature of Producer — Date

Applicant A

My producer has advised me that this long-term care insurance policy doesn't seem to be suitable for me. However, I still want the company to consider my application.

X _____ _____
Signature of Applicant A — Date

Applicant B

My producer has advised me that this long-term care insurance policy doesn't seem to be suitable for me. However, I still want the company to consider my application.

X _____ _____
Signature of Applicant B — Date

Someone from the company may contact you to discuss your answers and the suitability of this policy for you.

This Page Left Blank Intentionally.

Mutual of Omaha

Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza, Omaha, NE 68175

Submit Application To: Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901
Overnight Submission: Long-Term Care Service Office, 7805 Hudson Rd., Ste. 180, Woodbury, MN 55125-1591

☐ **New Business**
☐ **Reinstatement** (Policy Number _____)

☐ **Sponsored/Association Group**
☐ **Common Employer**
☐ **Producer**

Each Applicant acknowledges and agrees that if there is more than one Applicant on this application, all information provided may be reviewed or shared with the other Applicant. A completed and signed application will become part of each applicant's policy.

Section A GENERAL INFORMATION

	Applicant A	Applicant B
1	**Name:** Last Name First Name / Middle Initial	**Name:** Last Name First Name / Middle Initial
2	**Legal Residence Address:** Number, Street, Apartment Number City, State, ZIP Code	**Legal Residence Address *(If Different than Applicant A)*:** Number, Street, Apartment Number City, State, ZIP Code
3	**Contact Information:** ( ) – ( ) – Daytime Phone Number / Evening Phone Number : a.m. : p.m. Best Time to Call Within a 2-Hour Window (i.e., if 5p.m. is indicated, contact window is from 5:00-7:00 p.m.) Email Address May we contact you at this Email Address? ☐ Yes ☐ No	**Contact Information *(If Different than Applicant A)*:** ( ) – ( ) – Daytime Phone Number / Evening Phone Number : a.m. : p.m. Best Time to Call Within a 2-Hour Window (i.e., if 5p.m. is indicated, contact window is from 5:00-7:00 p.m.) Email Address May we contact you at this Email Address? ☐ Yes ☐ No
4	**Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐	**Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐
5	**Birth Date, Age and Sex at Birth:** ☐☐ / ☐☐ / ☐☐☐☐ ☐☐ Month / Day / Year / Age ☐ Male ☐ Female	**Birth Date, Age and Sex at Birth:** ☐☐ / ☐☐ / ☐☐☐☐ ☐☐ Month / Day / Year / Age ☐ Male ☐ Female
6	**Driver's License:** Do you have a valid Driver's License? ☐ Yes ☐ No If **"No,"** please explain _____	**Driver's License:** Do you have a valid Driver's License? ☐ Yes ☐ No If **"No,"** please explain _____
7	**Occupation:** Occupation	**Occupation:** Occupation

ICC20-MA6012 Rev

Section A (continued) GENERAL INFORMATION

Applicant A	Applicant B
8 Citizenship Status (check one):	**8 Citizenship Status** (check one):
☐ U.S. Citizen, or	☐ U.S. Citizen, or
☐ 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.	☐ 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.
☐ Neither, you are not eligible for this coverage.	☐ Neither, you are not eligible for this coverage.
9 Beneficiary:	**9 Beneficiary *(If Different than Applicant A)*:**
First Name, Middle Initial, Last Name	First Name, Middle Initial, Last Name
Number, Street, Apartment Number	Number, Street, Apartment Number
City, State, ZIP Code	City, State, ZIP Code
Relationship to You	Relationship to You

Section B ALLOWANCES

You may be eligible for allowances based on your answers to the following questions in this Section B.	**Applicant A** Yes	**Applicant A** No	**Applicant B** Yes	**Applicant B** No
1 Do you have a Partner?*	☐	☐	☐	☐
If **"Yes,"** complete (a) and (b):				
(a) Is he/she also applying for this coverage?	☐	☐	☐	☐
If **"Yes,"** provide full name only if not applying on this application				
(b) Does he/she have an existing Mutual of Omaha Insurance Company Long-Term Care policy/certificate?	☐	☐	☐	☐
If **"Yes,"** provide existing long-term care policy/certificate number(s)				
2 Are you or your Partner* a member of a Sponsored/Association Group endorsing this long-term care product?	☐	☐	☐	☐
If **"Yes,"** provide: Group Number 0				
Full Name of Organization				
Name and Relationship to Member				
Membership Number				
Membership Effective Date (Month / Year)				
3 Are you eligible for an employer allowance?	☐	☐	☐	☐
If **"Yes,"** provide: Group Number				
Group Name				
Employment Date				

*Partner means the one person who is: (a) your spouse to whom you are legally married; (b) your registered domestic partner or civil union partner; or (c) an adult person who: 1. shares a serious and committed personal relationship with you that is intended to be lifelong; 2. has shared a common permanent residence with you on a continuous basis for the most recent three years; 3. is not married, a domestic partner, a civil union partner, or in a committed personal relationship to anyone else; and 4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

Section C REPLACEMENT COVERAGE

Provide replacement coverage information.

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Do you currently have another long-term care insurance policy/certificate in force (including health care service contracts or health maintenance organization contracts)?	☐	☐	☐	☐
2	Did you have another long-term care insurance policy/certificate in force during the last 12 months?	☐	☐	☐	☐
3	Do you intend to replace other long-term care coverage or any of your medical or health insurance coverage with this policy? ..... If **"Yes,"** please read and sign the Notice to Applicant Regarding Replacement form included with this application.	☐	☐	☐	☐
4	**Question to be answered by the Producer:** Have you, **the Producer**, sold any health insurance, including long-term care policies, to Applicant A or Applicant B which: are still in force; or were sold in the last five years but are no longer in force?	☐	☐	☐	☐

If any question 1-4 was answered "Yes," in the above Section C, please provide details in C5 below.
(Attach additional signed page(s) if more space is needed.)

5 Applicant	Company Name/Address	Policy/ Certificate #	Plan Type*	Daily or Monthly Benefit	Status of Policy/Certificate	Annual Premium	To be Replaced by this Coverage	Sold by this Producer
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No

***Provide Plan Type abbreviation key: LTC=Long-Term Care, MS=Medicare Supplement, MM=Major Medical, OH=Other Health

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
6	Have you ever been declined, rated, or denied reinstatement for long-term care insurance? ..... If **"Yes,"** provide details below. (Attach additional signed page(s) if more space is needed.) **Producer, If "Yes," contact the LTC Underwriting Department before submitting the application.**	☐	☐	☐	☐

Applicant	Company Name(s)	When	Why
☐ A ☐ B			
☐ A ☐ B			

Section D HEALTH INSURABILITY QUESTIONS

If you answer "Yes" to any of the questions in this Section D, we are unable to accept this application or offer you Long-Term Care Insurance. Do not continue.

		Applicant A		Applicant B	
		Yes	No	Yes	No
1	Do you currently use any of the following? • quad cane • walker • wheelchair • electric scooter • stairlift • hospital bed • respirator • nebulizer • oxygen	☐	☐	☐	☐
2	Within the past 6 months have you been confined to, used, or been advised to have, any of the following? • residential care, assisted living or adult day care facility services • nursing home or home health care services	☐	☐	☐	☐
3	Do you require the assistance or supervision of another person or a device of any kind for any of the following? • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐	☐	☐
4	Have you ever been diagnosed as having, or received medical advice or medical care by a member of the medical profession for any of the following? • Alzheimer's Disease • Huntington's Chorea • Parkinson's Disease • Dementia • Chronic Hepatitis • Systemic Lupus • Memory Loss • Cirrhosis • Multiple Sclerosis (MS) • Mild Cognitive Impairment • Hydrocephalus • Muscular Dystrophy • Organic Brain Syndrome • Multiple Myeloma • Myasthenia Gravis • Schizophrenia • Psychosis • Scleroderma • Intellectual Developmental Disorder • Organ Transplant • Paralysis • Connective Tissue Disease • Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease) • Kidney Failure or received Dialysis • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, or 2 or more strokes or TIAs • Diabetes for 20 years or more, or currently taking more than 50 units of insulin daily, or with peripheral neuropathy, retinopathy, nephropathy or a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast or prostate cancers) in the past 2 years	☐	☐	☐	☐
5	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)?	☐	☐	☐	☐
6	Do you currently qualify for payment or are you receiving payment benefits under Medicaid (not Medicare), disability income plan, workers' compensation, Social Security disability or any federal or state disability plan?	☐	☐	☐	☐
7	Do you receive Veterans Administration disability for a mental nervous condition or post-traumatic stress disorder (PTSD)?	☐	☐	☐	☐
8	Do you have an active Power of Attorney currently making health or financial decisions on your behalf?	☐	☐	☐	☐

Section E PRIMARY PHYSICIAN INFORMATION AND MEDICATION

Applicant A

1 Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years:

Primary Name

Address

City, State, ZIP Code

Phone Number

2 Date of Last Visit:

Month / Year

3 Why did you last see this physician?

4 Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:

Month / Year

5 Medication:

Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any physician recommended over-the-counter medication(s), including injections, on a weekly basis or more frequently?

☐ Yes, details provided on next page.

☐ No

Do you have a prescription for medical marijuana or tetrahydrocannabinol (THC)?

☐ Yes

☐ No

Applicant B

1 Provide the name, address and phone number of your primary physician if you have consulted within the last 10 years *(If Different than Applicant A)*:

Primary Name

Address

City, State, ZIP Code

Phone Number

2 Date of Last Visit:

Month / Year

3 Why did you last see this physician?

4 Date of last complete physical exam and blood work (basic metabolic chemistry panel) in the last 2 years:

Month / Year

5 Medication:

Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any physician recommended over-the-counter medication(s), including injections, on a weekly basis or more frequently?

☐ Yes, details provided on next page.

☐ No

Do you have a prescription for medical marijuana or tetrahydrocannabinol (THC)?

☐ Yes

☐ No

If "Yes," to question 5, please list on the next page all the medication name(s) using pharmacy label, dosage, how often you take, how long have you taken, prescribed by, why you take, when and why for any dosage increase or decrease. (Attach additional signed page(s) if more space is needed.)

Section F MEDICATION INFORMATION

Please list all physician recommended over-the-counter or prescription medications, including injections, you have taken in the past 12 months in the table below.

Applicant A

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Applicant B

Medication Name (copy off pharmacy label)	Dosage	How often do you take?	How long have you taken?	Prescribed by Primary Physician? If no, provide below.	Why do you take this medication? (Diagnosis/Condition)
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Explain when and why if your dosage was increased or decreased in the past 12 months on any medications you listed above. Also provide medication name and prescribing physician name, address and phone number if other than your primary physician.

Section G ADDITIONAL HEALTH QUESTIONS

		Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1	Have you ever received any advice, treatment, consultation or diagnosis by a member of the medical profession for any of the following conditions?				
	The following conditions require a stability period ranging from 3 months to 5 years to be eligible for coverage. Refer to our Underwriting Guidelines to insure the stability period has been met.				
	(a) Anemia, Blood Clotting or Blood Disease/Disorder	☐	☐	☐	☐
	(b) Arthritis, Broken Bone, Back, Spinal Stenosis, Scoliosis, Bone or Joint Disorder	☐	☐	☐	☐
	(c) Autoimmune Disease/Disorder	☐	☐	☐	☐
	(d) Balance or Gait Disorder	☐	☐	☐	☐
	(e) Cancer, Leukemia or Lymphoma	☐	☐	☐	☐
	(f) Chronic Pain, Amputation or Polymyalgia Rheumatica	☐	☐	☐	☐
	(g) Depression, Anxiety or other Mental Disorder	☐	☐	☐	☐
	(h) Diabetes	☐	☐	☐	☐
	(i) Digestive Disorder	☐	☐	☐	☐
	(j) Fibromyalgia or Chronic Fatigue Syndrome	☐	☐	☐	☐
	(k) Heart Rhythm, Heart Valve, Coronary Artery or Heart Disease/Disorder	☐	☐	☐	☐
	(l) Hepatitis or Liver Disease/Disorder	☐	☐	☐	☐
	(m) High Blood Pressure	☐	☐	☐	☐
	(n) Immune System Disease/Disorder	☐	☐	☐	☐
	(o) Incontinence or other Bowel or Bladder Disease/Disorder	☐	☐	☐	☐
	(p) Kidney Disease/Disorder	☐	☐	☐	☐
	(q) Lung Disease/Disorder	☐	☐	☐	☐
	(r) Nerve Damage or other Neurological Disease/Disorder	☐	☐	☐	☐
	(s) Osteoporosis or Osteopenia	☐	☐	☐	☐
	(t) Seizure Disorder, Epilepsy or Tremor Disease/Disorder	☐	☐	☐	☐
	(u) Shingles	☐	☐	☐	☐
	(v) Stroke, Transient Ischemic Attack, Aneurysm, Carotid or Circulatory Disease/Disorder	☐	☐	☐	☐
	(w) Vertigo	☐	☐	☐	☐
	(x) Vision Disorder	☐	☐	☐	☐
2	In the past 5 years have you been diagnosed with, treated for, had testing for, or consulted with a medical professional for conditions or diagnosis not listed above?	☐	☐	☐	☐
3	Do you have, for your use, a handicap parking sticker or handicap license plate?	☐	☐	☐	☐
4	In the past 3 years has a medical professional referred you to a specialist for additional consultation, testing, or surgery?	☐	☐	☐	☐
5	**Are you scheduled for a visit with a medical professional within the next 6 months?**	☐	☐	☐	☐
6	Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?	☐	☐	☐	☐
7	Have you received inpatient or outpatient treatment at a hospital, surgical center, or rehabilitation facility in the past 12 months?	☐	☐	☐	☐
8	What is your height?	' "		' "	
9	What is your weight?	lbs		lbs	
10	Have you had an unplanned weight change in the past 12 months?	☐	☐	☐	☐
11	In the past 5 years have you received treatment from a medical professional for a head injury or concussion?	☐	☐	☐	☐
12	In the past 5 years have you received treatment from a medical professional for falls or fractures?	☐	☐	☐	☐

Section G (continued) ADDITIONAL HEALTH QUESTIONS

If "Yes," to any additional health questions in Section G, please provide the following details for each "Yes" answer below.
(Attach additional signed page(s) if more space is needed.)

Applicant A

	Health Condition/Details	Month/ Year Diagnosed	Month/ Year for Last Visit	Reason for Last Visit	Month/ Year for Next Visit	Reason for Next Visit	Physician or Facility Name, Address and Phone Number
Ques # _____							
Ques # _____							
Ques # _____							
Ques # _____							

Applicant B

Ques # _____							
Ques # _____							
Ques # _____							
Ques # _____							

Section H MEDICAL HEALTH HISTORY

	Applicant A	Applicant B
1	To the best of your knowledge has your biological mother, father, or sibling been **formally** diagnosed by a member of the medical profession with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No If **"Yes,"** Relationship? _____ Diagnosis date? _____	To the best of your knowledge has your biological mother, father, or sibling been **formally** diagnosed by a member of the medical profession with Alzheimer's Disease or other form of dementia? ☐ Yes ☐ No If **"Yes,"** Relationship? _____ Diagnosis date? _____
2	Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____	Have you been hospitalized or had surgery in the past 3 years? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____
3	Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____	Have you been advised by a member of the medical profession in the last 5 years to have surgery which has not yet been completed? ☐ Yes ☐ No If **"Yes,"** Why? _____ When? _____
4	Have you received physical, occupational, speech therapy or cardiac rehabilitation in the past 12 months? ☐ Yes ☐ No If **"Yes,"** Why? _____ Date of last therapy? _____ Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No	Have you received physical, occupational, speech therapy or cardiac rehabilitation in the past 12 months? ☐ Yes ☐ No If **"Yes,"** Why? _____ Date of last therapy? _____ Has a member of the medical profession advised that additional therapy will be needed? ☐ Yes ☐ No
5	Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No If **"Yes,"** Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No If **"Yes,"** How often do you use it? _____ If **"No,"** Explain _____	Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for sleep apnea? ☐ Yes ☐ No If **"Yes,"** Do you use CPAP, BiPAP, or a dental device? ☐ Yes ☐ No If **"Yes,"** How often do you use it? _____ If **"No,"** Explain _____
6	Have you used insulin in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Units used each day? _____ Year insulin was first prescribed? _____	Have you used insulin in the past 6 months? ☐ Yes ☐ No If **"Yes,"** Units used each day? _____ Year insulin was first prescribed? _____
7	In the last 12 months, have you used any form of tobacco or any form of nicotine replacement/cessation product (such as nicotine gum, patch, spray, e-cigarette, vapor, etc.)? ☐ Yes ☐ No If **"Yes,"** date last used? _____	In the last 12 months, have you used any form of tobacco or any form of nicotine replacement/cessation product (such as nicotine gum, patch, spray, e-cigarette, vapor, etc.)? ☐ Yes ☐ No If **"Yes,"** date last used? _____
8	During the last 10 years, have you ever used unlawful drugs (excluding marijuana), or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No If **"Yes,"** Substance? _____ Date last used? _____	During the last 10 years, have you ever used unlawful drugs (excluding marijuana), or used prescription medications other than as prescribed by your doctor? ☐ Yes ☐ No If **"Yes,"** Substance? _____ Date last used? _____
9	Do you use recreational marijuana? ☐ Yes ☐ No If **"Yes,"** Frequency of use? _____ Method of ingestion? _____	Do you use recreational marijuana? ☐ Yes ☐ No If **"Yes,"** Frequency of use? _____ Method of ingestion? _____
10	Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No If **"Yes,"** date last treatment, consultation or hospitalization? _____	Have you ever received medical treatment, counseling or been hospitalized for drug use? ☐ Yes ☐ No If **"Yes,"** date last treatment, consultation or hospitalization? _____
11	Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No	Do you regularly consume 4 or more alcoholic beverages per day, or do you drink 5 or more drinks per day, 1 or more days per week? ☐ Yes ☐ No
12	Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No If **"Yes,"** Month and year of treatment, consultation or hospitalization? _____ Month and year you last consumed alcohol? _____	Have you ever received medical treatment, counseling or been hospitalized for alcohol use? ☐ Yes ☐ No If **"Yes,"** Month and year of treatment, consultation or hospitalization? _____ Month and year you last consumed alcohol? _____

INSTRUCTIONS: Complete Section I for MUTUALCARE SECURE SOLUTION – OR – Section J for MUTUALCARE CUSTOM SOLUTION.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section I — MUTUALCARE SECURE SOLUTION

Applicant A

☐ **MutualCare Secure Solution**

Applicant B (If selecting Shared Care Benefit, benefits must be identical to Applicant A)

☐ **MutualCare Secure Solution**

Standard MutualCare Secure Solution Benefits:

- NH, ALF and HHC Benefits are each up to 100% of the MMB
- Cash Benefit is 25% of HHC Benefit up to a maximum of $2,000
- 90-Day Elimination Period

1 Maximum Monthly Benefit (MMB) (must enter):

$_____ per month

($1,500-$10,000 in $1 increments)

2 Policy Limit = number of months selected (must check one) multiplied by the MMB:

- ☐ 24 months (2 Year)
- ☐ 36 months (3 Year)
- ☐ 48 months (4 Year)
- ☐ 60 months (5 Year)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit (must check "YES" or "NO") If "**NO**," signature required:

- ☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**
- ☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X _____

Signature of Applicant A

If you selected "NO" to the 5% Compound Lifetime Benefit, check one Inflation Option below:

- ☐ No Inflation Protection
- ☐ 3% Lifetime Benefit
- ☐ 4% Lifetime Benefit
- ☐ 3% Limited Period Benefit - 20 Year
- ☐ 5% Limited Period Benefit - 20 Year

4 Nonforfeiture Benefit – Shortened Benefit Period (must check "YES" or "NO"):

- ☐ **YES**
- ☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

1 Maximum Monthly Benefit (MMB) (must enter):

$_____ per month

($1,500-$10,000 in $1 increments)

2 Policy Limit = number of months selected (must check one) multiplied by the MMB:

- ☐ 24 months (2 Year)
- ☐ 36 months (3 Year)
- ☐ 48 months (4 Year)
- ☐ 60 months (5 Year)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit (must check "YES" or "NO") If "**NO**," signature required:

- ☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**
- ☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X _____

Signature of Applicant B

If you selected "NO" to the 5% Compound Lifetime Benefit, check one Inflation Option below:

- ☐ No Inflation Protection
- ☐ 3% Lifetime Benefit
- ☐ 4% Lifetime Benefit
- ☐ 3% Limited Period Benefit - 20 Year
- ☐ 5% Limited Period Benefit - 20 Year

4 Nonforfeiture Benefit – Shortened Benefit Period (must check "YES" or "NO"):

- ☐ **YES**
- ☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Complete Section I Optional Benefits for MUTUALCARE SECURE SOLUTION to change or add benefits.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section I (continued) OPTIONAL BENEFITS FOR MUTUALCARE SECURE SOLUTION

Applicant A	Applicant B
5 ALF Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50%	**5 ALF Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50%
6 HHC Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.	**6 HHC Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.
7 Calendar Day Elimination Period: **(90-Day Elimination Period is default if no option selected)** ☐ 180 Day ☐ 365 Day	**7 Calendar Day Elimination Period:** **(90-Day Elimination Period is default if no option selected)** ☐ 180 Day ☐ 365 Day
8 ☐ **Waiver of Elimination Period for HHC Benefit**	**8** ☐ **Waiver of Elimination Period for HHC Benefit**
9 ☐ **Shared Care Benefit** Only available when both Partners apply at the same time and both policies are issued with identical benefits.	**9**
10 ☐ **Security Benefit** Not available for issue ages 70 and older, with Shared Care Benefit or if Partner is applying for this coverage. _____ Partner's Name	**10**
11 Return of Premium at Death Benefit: ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)	**11 Return of Premium at Death Benefit:** ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid)

If you completed Section I for MUTUALCARE SECURE SOLUTION – SKIP Section J and continue to Section K.

Complete Section J for MUTUALCARE CUSTOM SOLUTION if Section I for MUTUALCARE SECURE SOLUTION was not selected.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section J — MUTUALCARE CUSTOM SOLUTION

Applicant A

☐ **MutualCare Custom Solution**

Applicant B (If selecting Shared Care Benefit, benefits must be identical to Applicant A)

☐ **MutualCare Custom Solution**

Standard MutualCare Custom Solution Benefits:

- NH, ALF and HHC Benefits are each up to 100% of the MMB
- Cash Benefit is 25% of HHC Benefit up to a maximum of $2,000
- 90-Day Elimination Period

1 Maximum Monthly Benefit (MMB) (must enter):

$_____ per month

($1,500-$10,000 in $50 increments)

1 Maximum Monthly Benefit (MMB) (must enter):

$_____ per month

($1,500-$10,000 in $50 increments)

2 Policy Limit (must enter):

$_____

($50,000-$500,000 in $500 increments)

2 Policy Limit (must enter):

$_____

($50,000-$500,000 in $500 increments)

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If "**NO**," signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X _____
Signature of Applicant A

If you selected "NO" to the 5% Compound Lifetime Benefit, check either No Inflation Option, OR select an alternate Inflation Option below:

☐ No Inflation Protection

OR

Select one of the following inflation percentage options:

☐ 1%	☐ 1.25%	☐ 1.50%	☐ 1.75%
☐ 2%	☐ 2.25%	☐ 2.50%	☐ 2.75%
☐ 3%	☐ 3.25%	☐ 3.50%	☐ 3.75%
☐ 4%	☐ 4.25%	☐ 4.50%	☐ 4.75%
☐ 5%			

(Compound Lifetime with Buy-Up is default if no optional Limited Period Benefit selected below.)

☐ 10 Year with Buy-Up
☐ 15 Year with Buy-Up
☐ 20 Year with Buy-Up

3 Compound Inflation Protection Benefit:

5% Compound Lifetime Benefit
(must check "YES" or "NO") If "**NO**," signature required:

☐ **YES, I am selecting the 5% Compound Inflation Protection Lifetime Benefit**

☐ **NO, 5% Compound Inflation Protection Lifetime Benefit is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection Lifetime Benefit option. Specifically, I have reviewed the option for Compound Inflation increases, and I reject the 5% Compound Inflation Protection Lifetime Benefit option.

X _____
Signature of Applicant B

If you selected "NO" to the 5% Compound Lifetime Benefit, check either No Inflation Option, OR select an alternate Inflation Option below:

☐ No Inflation Protection

OR

Select one of the following inflation percentage options:

☐ 1%	☐ 1.25%	☐ 1.50%	☐ 1.75%
☐ 2%	☐ 2.25%	☐ 2.50%	☐ 2.75%
☐ 3%	☐ 3.25%	☐ 3.50%	☐ 3.75%
☐ 4%	☐ 4.25%	☐ 4.50%	☐ 4.75%
☐ 5%			

(Compound Lifetime with Buy-Up is default if no optional Limited Period Benefit selected below.)

☐ 10 Year with Buy-Up
☐ 15 Year with Buy-Up
☐ 20 Year with Buy-Up

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

4 Nonforfeiture Benefit – Shortened Benefit Period
(must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Complete Section J Optional Benefits for MUTUALCARE CUSTOM SOLUTION to change or add benefits.

Benefit abbreviation key: NH=Nursing Home, ALF=Assisted Living Facility, HHC=Home Health Care, MMB=Maximum Monthly Benefit

Section J (continued) OPTIONAL BENEFITS FOR MUTUALCARE CUSTOM SOLUTION

Applicant A	Applicant B
5 ALF Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50%	**5 ALF Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50%
6 HHC Benefit Reduced from 100% of MMB to: ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.	**6 HHC Benefit Reduced from 100% of MMB to:** ☐ 75% ☐ 50% Reducing the **HHC Benefit** will reduce the **Cash Benefit**.
7 Calendar Day Elimination Period: **(90-Day Elimination Period is default if no option selected)** ☐ 0 Day ☐ 30 Day ☐ 60 Day ☐ 180 Day ☐ 365 Day	**7 Calendar Day Elimination Period:** **(90-Day Elimination Period is default if no option selected)** ☐ 0 Day ☐ 30 Day ☐ 60 Day ☐ 180 Day ☐ 365 Day
8 ☐ **Waiver of Elimination Period for HHC Benefit**	**8** ☐ **Waiver of Elimination Period for HHC Benefit**
9 ☐ **Professional HHC Benefit**	**9** ☐ **Professional HHC Benefit**
10 Partner Benefits: The **Joint Waiver of Premium, Survivorship Benefit** and **Shared Care Benefit** are only available when both Partners apply at the same time and both policies are issued. ☐ **Joint Waiver of Premium** ☐ **Survivorship Benefit** ☐ **Shared Care Benefit** The **Shared Care Benefit** is only available when both policies are issued with identical benefits.	**10**
11 ☐ **Security Benefit** Not available for issue ages 70 and older, with other Partner Benefits or if Partner is applying for this coverage. _____ Partner's Name	**11**
12 Return of Premium at Death Benefit: ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid) **OR** ☐ Return of Premium (Minus Claims Paid) If Death Occurs Before Age 65 **OR** ☐ Return of Premium at Death (Minus Claims Paid)	**12 Return of Premium at Death Benefit:** ☐ 3 x MMB Return of Premium at Death (Minus Claims Paid) **OR** ☐ Return of Premium (Minus Claims Paid) If Death Occurs Before Age 65 **OR** ☐ Return of Premium at Death (Minus Claims Paid)

Continue to Section K.

ICC20-MA6012 Rev

Section K PROTECTION AGAINST UNINTENTIONAL LAPSE

Must check the applicable box. Complete the requested information if you designate an additional person. You may want to consider designating someone other than your Partner. The designee cannot be the producer unless related to the applicant.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

Applicant A	**Applicant B**
☐ I elect NOT to designate any person to receive such notice.	☐ I elect NOT to designate any person to receive such notice.
OR	**OR**
☐ I designate the following person to receive notice of lapse or termination of the policy due to nonpayment of premium:	☐ I designate the following person to receive notice of lapse or termination of the policy due to nonpayment of premium: ***(If Different than Applicant A)***
Name (Print full name of other person to receive notice of lapse or termination)	Name (Print full name of other person to receive notice of lapse or termination)
Street Address, Apartment Number	Street Address, Apartment Number
City, State, ZIP Code	City, State, ZIP Code

Section L 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: an Attending Physician's Statement, medical records, an underwriting assessment, a medical examination, or other information for underwriting purposes.
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 additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement), and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage 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. 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 long-term care 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. A completed and signed application will become part of each applicant's policy.
6. Applicant acknowledges that no Producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
7. Applicant acknowledges receipt of an Outline of Coverage, Shopper's Guide to Long-Term Care Insurance, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, Potential Rate Increase Disclosure Form and, if applicable, *Guide to Health Insurance for People with Medicare*.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Caution: If your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company has the right to deny benefits or rescind your policy.

I have read and understand this Agreements and Acknowledgements Section, including the Fraud Warning and I approve all my answers as recorded in this application.

Signed at _____ City _____ State

X _____ Signature of Applicant A _____ Date

Signed at _____ City _____ State

X _____ Signature of Applicant B _____ Date

I/We, the Producer(s) certify that each question was asked exactly as written and I/we have recorded the answers provided by the Applicant(s) completely and accurately. I/We also agree that my/our answers in this application are true and complete.

☐ **Yes** ☐ **No** (If "No," please explain) _____

X _____ Signature of Licensed Producer

X _____ Signature of Other Licensed Producer, if applicable

Applications must be received within 30 days following applicant signature. If received outside of 30 days, a new application must be completed and submitted.

ICC20-MA6012 Rev

PREMIUM INFORMATION

Applicant A	Applicant B
1 Premium Option:	**1 Premium Option:**
☑ Lifetime	☑ Lifetime
2 Select Effective Date:	**2 Select Effective Date:**
☐ Date Policy is Issued	☐ Date Policy is Issued
☐ For Replacements Only, Requested Effective Date of Coverage _____ (up to 60 days from application date)	☐ For Replacements Only, Requested Effective Date of Coverage _____ (up to 60 days from application date)
3 Recurring Premium Payment: (Annual Direct Bill Mode is default if no option selected)	**3 Recurring Premium Payment: (Annual Direct Bill Mode is default if no option selected)**
Modal Premium: $ _____	Modal Premium: $ _____
☐ Annual Direct Bill	☐ Annual Direct Bill
☐ Semiannual Direct Bill	☐ Semiannual Direct Bill
☐ Quarterly Direct Bill	☐ Quarterly Direct Bill
☐ Monthly Automatic Bill Pay **Note: Complete and Sign Payment Authorization below.**	☐ Monthly Automatic Bill Pay **Note: Complete and Sign Payment Authorization below.**

Payment Authorization
(Complete and Sign if Recurring Monthly Automatic Bill Pay Selected.)

Specify the date Recurring premiums will be withdrawn (1st through the 28th of the month): _____	Specify the date Recurring premiums will be withdrawn (1st through the 28th of the month): _____
Bank Name:_____	Bank Name:_____
Complete information below or attach a voided check.	Complete information below or attach a voided check.
Bank Routing Number:_____	Bank Routing Number:_____
Bank Account Number: _____ (Do not use Debit/Credit Card numbers)	Bank Account Number: _____ (Do not use Debit/Credit Card numbers)

When choosing automatic bill pay, **MONEY MAY BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE, BUT IN NO EVENT LATER THAN THE DATE ALL DELIVERY REQUIREMENTS ARE RECEIVED**. The first withdrawal date or charge date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the withdrawal or charge may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the monthly renewal premiums as indicated above. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

X _____ _____ Authorized Signature as Shown on Account Date	X _____ _____ Authorized Signature as Shown on Account Date

SUBMIT TO LTC SERVICE OFFICE

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB, LLC, state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me to release Personal Information about me to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

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 this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my Personal Information to MIB, LLC. I understand that my Personal Information received by MIB, LLC may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that if the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand if I refuse to sign, the insurance for which I am applying will not be 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. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Applicant acknowledges and agrees that if there is more than one Applicant on this application, all information provided may be reviewed or shared with the other Applicant. A completed and signed application will become part of each applicant's policy.

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

_____

Printed Name of Applicant A	Birth Date	Birth State	Printed Name of Applicant B	Birth Date	Birth State
X _____ Signature of Applicant A		Date	X _____ Signature of Applicant B		Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS.

ICC13-M28367

Submit to LTC Service Office

PRODUCER STATEMENT

	Yes	No
1. I/We certify that each question was asked exactly as written and that I/we recorded the answers completely and accurately	☐	☐
2. I/We certify that the application was completed in the physical presence of the Applicant(s)	☐	☐
(If "No," explain) _____		
3. This coverage is written on myself (the Producer) and/or my Partner	☐	☐
Partner's name _____		

	Applicant A	Applicant B
4. Please indicate the Underwriting Risk classification quoted		
Your quote will be noted, however, Underwriting will determine the final risk classification. We suggest quoting Select unless our Underwriting Guide indicates the health condition(s) warrants a substandard rating. Class II cases should be discussed with an underwriter prior to application submission.		
	☐ Preferred	☐ Preferred
	☐ Select	☐ Select
	☐ Class I	☐ Class I
	☐ Class II	☐ Class II
5. To the best of my knowledge, replacement of other insurance (check box) involved in this transaction		
If replacement is involved, I/we shall comply with all state and/or company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.		
	☐ is	☐ is
	☐ is not	☐ is not

By signing below, I understand I am required to have valid LTCi training completed at time of application. I further understand that if the appropriate LTCi training required by the state in which this application is signed is not valid, this application will not be processed and a new application will be required in order to continue the underwriting process.

X _____ _____
Signature of Producer (Agent of Record) Date

X _____ _____
Signature of Other Producer, if applicable Date

Producer Information (please print clearly)

For Mutual of Omaha Career Producers Only: **01**
Manager Stamp

For Brokerage Only: Commission Code ☐☐ 951300 (**Examples:** 8 8, A 2, etc.)
(Commission Code available from your marketing organization)

Agent of Record:

Producer's Name _____ Last 4 of Social Security # _____ Comm. % Share _____
Identification # _____ Phone _____ Email _____

If applicable, for Commission Split:

Other Producer's Name _____ Last 4 of Social Security # _____ Comm. % Share _____
Identification # _____ Phone _____ Email _____

Other Producer's Name _____ Last 4 of Social Security # _____ Comm. % Share _____
Identification # _____ Phone _____ Email _____

Whom should we contact with questions regarding this application if different than Producer listed above:
(please print clearly)

Name _____

Name of Office/Corporation _____

Phone Number _____

Email Address

_____

SUBMIT TO LTC SERVICE OFFICE

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Long-Term Care Insurance

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

Save this notice! It may be important to you in the future.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. 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.

X
Signature of Producer

Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X
Signature of Applicant A — Date

X
Signature of Applicant B — Date

ICC13-M28368

Submit to LTC Service Office

Acknowledgement of Nonduplication

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

PLEASE READ CAREFULLY BEFORE SIGNING

I, X _____
Producer's Name
certify that I have done the following.

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of the policy.
2. Reviewed the policies listed below and have found that duplication WILL ☐ or WILL NOT ☐ *(check one)* occur with the issuance of the applied-for policy.

_____
(Form Number(s))

COMPANY	POLICY NUMBER	TYPE OF POLICY

Check one:

☐ (a) Duplication will not occur because the above-listed policy number(s) _____ will be replaced by the applied-for policy _____ *(form number(s))*. Justification for the replacement is *(explain benefit to consumer)*

_____
_____

☐ (b) No health policies in force at this time.

☐ (c) Applicant has elected not to have the policy (policies) reviewed.

X _____ _____
Signature of Producer Date

NOTICE TO CONSUMERS AGE 65 AND OLDER

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
   - SPECIFIED DISEASE (CANCER, STROKE, ETC.).
   - HOSPITAL INDEMNITY.
   - BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS).
   - LONG-TERM CARE.

   THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.
2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES, YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS OR WAITING PERIODS MUST BE SERVED.
4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE PRODUCER OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant A Date

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant B Date

M18252_1108

Submit to LTC Service Office

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

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: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

Submit to LTC Service Office

CLIENT FORMS

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s) if applicable.

Required Forms to be Left with Applicant(s)				
Replacement Notice *(if applicable)*	MIB, LLC Pre-Notice	Things You Should Know Before You Buy Long-Term Care Insurance	Long-Term Care Insurance Potential Rate Increase Disclosure Form	
Acknowledgement of Nonduplication *(applicable for age 65 and older)*		Authorization for Release of Information to My Insurance Agent and/or Agency *(if applicable)*		Outline of Coverage

Not Contained within this Application Package:

Required Forms to be Left with Applicant(s) that are Not Included within this Package	
LTC Shopper's Guide *(Not included within this package. Please provide in addition.)*	Guide to Medicare for People Age 65 and Older *(Not included within this package. If applicable, please provide in addition.)*

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Long-Term Care Insurance

Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance

Save this notice! It may be important to you in the future.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. 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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. 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.

X
Signature of Producer

Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X
Signature of Applicant A — Date

X
Signature of Applicant B — Date

ICC13-M28368

MIB, LLC PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, LLC which operates an information exchange on behalf of insurance companies that are members of the MIB Group, Inc. 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. 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 Park, Suite 400, Braintree, MA 02184-8734.

Mutual of Omaha Insurance Company, 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "A Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. For more information about the Senior health insurance counseling program in your state, contact the state agency listed in the Directories in the above mentioned Shopper's Guide to Long-Term Care Insurance.

Facilities

Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

ICC13-M28369

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

Long-Term Care Insurance Potential Rate Increase Disclosure Form

1. **Premium Rate**: Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is: Applicant A $ _____ Applicant B $ _____
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:**

   The premium rates for this policy may change. Any change will be effective on the next billing date after the company has provided you at least 60 days written notice before we change premiums.
4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**
If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the greater of the total amount of premiums you've paid since your policy was first issued or the maximum monthly benefit. If you have already received benefits under the policy, so that the remaining lifetime maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:
- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

ICC13-M28370

Leave this page with Applicant(s)

Acknowledgement of Nonduplication

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

PLEASE READ CAREFULLY BEFORE SIGNING

I, X _____
Producer's Name
certify that I have done the following.

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of the policy.
2. Reviewed the policies listed below and have found that duplication WILL ☐ or WILL NOT ☐ *(check one)* occur with the issuance of the applied-for policy.

_____
(Form Number(s))

COMPANY	POLICY NUMBER	TYPE OF POLICY

Check one:

☐ (a) Duplication will not occur because the above-listed policy number(s) _____ will be replaced by the applied-for policy _____ *(form number(s))*. Justification for the replacement is *(explain benefit to consumer)*

_____
_____

☐ (b) No health policies in force at this time.

☐ (c) Applicant has elected not to have the policy (policies) reviewed.

X _____ _____
Signature of Producer Date

NOTICE TO CONSUMERS AGE 65 AND OLDER

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:
   - SPECIFIED DISEASE (CANCER, STROKE, ETC.).
   - HOSPITAL INDEMNITY.
   - BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS).
   - LONG-TERM CARE.

   THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES. THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.
2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.
3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES, YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS OR WAITING PERIODS MUST BE SERVED.
4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE PRODUCER OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant A Date

I certify that my right to have all of my existing health policies examined has been explained to me by the producer named above.

☐ I have been informed that the policy for which I am applying WILL ☐ or WILL NOT ☐ *(check one)* result in duplicate coverage.

☐ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice.

X _____ _____
Signature of Applicant B Date

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

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: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

Leave this page with Applicant(s)

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175 1-877-894-2478

INDIVIDUAL LONG-TERM CARE INSURANCE OUTLINE OF COVERAGE FOR POLICY SERIES LTC13 TAX-QUALIFIED

NOTICE TO BUYER: This policy may not cover all of the costs associated with long-term care incurred by you during the period of coverage. You are advised to review carefully all policy limitations.

CAUTION: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application will be attached to and made part of any issued policy. If your answers are incomplete, incorrect, or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers are incorrect, contact Mutual of Omaha Insurance Company at this address: Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901.

1. POLICY DESIGNATION – INDIVIDUAL COVERAGE

This is an individual policy of insurance.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. **This is not an insurance contract, but only a summary of coverage.** Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and us. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY**!

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE - PREMIUMS MAY CHANGE

This policy is guaranteed renewable. This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premium on time. Mutual of Omaha Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

WAIVER OF PREMIUM BENEFIT

If you meet the policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, you will not need to pay premiums for the policy effective on the date we begin paying: nursing home benefits; assisted living facility benefits; at least eight days of home health care or adult day care benefits in any month; or the monthly cash benefit, if the Cash Benefit Rider is attached to the policy. Once waiver of premium ends, you must resume paying premiums to keep the policy in force.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

The premium for your policy can change. We will not increase premium due to a change in your age or health or your use of the long-term care coverage. However, we can change premiums if we make the same change for all persons of the same class, but never more than once per year. We will notify you at least 60 days before we change premiums for your class. Your premium rates will also increase when you purchase additional coverage after the policy effective date, such as an increased level of inflation protection.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

(a) **30-DAY FREE LOOK:** You have 30 days from the date of its delivery to review the policy. If during that time you are not satisfied with the policy, you may return it to us or to your agent. We will refund all premiums paid within 30 days of the return directly to the payer. The policy will then be considered never to have been issued.

(b) **REFUND OF UNEARNED PREMIUM:** The policy contains a provision for the return of unearned premium in the event of termination due to death or cancellation. Upon receipt of notice that you cancelled the policy or that you have died, we will refund the pro-rata portion of any unearned premium paid for the period after your death or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* available from Mutual of Omaha Insurance Company. Neither Mutual of Omaha Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide for one or more necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy pays benefits for expenses you incur for covered long-term care expenses. Payment is subject to the *elimination period*, exclusions, and all other terms of the policy and riders.

9. BENEFITS PROVIDED BY THE POLICY

ELIMINATION PERIOD

Elimination period means the initial number of calendar days that you must be *chronically ill* before we will pay benefits under your policy. The *elimination period* begins on the first day you are *chronically ill* and receive a covered service. Subsequent days on which you are *chronically ill* will be used to satisfy the *elimination period*, even if you do not receive a covered service on those days. If you cease to be *chronically ill* during the *elimination period*, the *elimination period* will stop. The *elimination period* will resume on the next date that you are *chronically ill* and receive a covered service.

Your policy's *elimination period* must be satisfied only once in your lifetime. Any days for which Medicare pays benefits for qualified long-term care services can be used to satisfy the *elimination period*. The *elimination period* applies to all benefits unless otherwise stated in a specific benefit provision.

BENEFIT LIMITS

We will pay benefits up to their applicable maximum amounts or until the policy limit has been reduced to zero, whichever occurs first. Except as otherwise provided in the policy, any benefits we pay under the policy will reduce the amount of the policy limit. Refer to your completed application for the level of coverage and features selected.

COVERED SERVICES

Covered services means services or supplies you receive for which a benefit may be payable under your policy. You must incur actual charges in order for services and supplies to be *covered services*. A service must also be a qualified long-term care service in order to be considered a *covered service*.

BASIC POLICY BENEFITS

CARE COORDINATOR SERVICE

The care coordinator service is voluntary and available to you at no cost to assist you in managing and arranging your long-term care needs. The care coordinator offers knowledge, training, and experience, and can help you to make the best use of the policy's benefits. You do not need to satisfy the *elimination period* in order to use the care coordinator service. If you wish to use this service, the care coordinator will contact you to:

(a) evaluate your specific needs for care and services;

(b) develop your initial and subsequent plans of care;

(c) assist you in obtaining the services and facilities outlined in the plan of care; and

(d) monitor your progress and the quality of the care you receive on an ongoing basis.

Stay-at-home benefits and the alternate care benefit are only available if you use a care coordinator. You do not need to use a care coordinator to receive any other benefits under the policy. We do not require you to use the providers identified in the plan of care developed by a care coordinator.

HOME HEALTH CARE BENEFITS

If you receive home health care from a home health care agency or an independent provider, we will pay the expense you incur for covered services, up to the Home Health Care Maximum Monthly Benefit for each month you receive such services. Home health care benefits begin after you have satisfied the policy's *elimination period*. *Covered services* for home health care consist of:

(a) part-time or intermittent skilled services provided by a nurse;

(b) services to help you comply with your medication/treatment regimen;

(c) home health aide services;

(d) physical therapy, respiratory therapy, occupational therapy, speech therapy, or audiology therapy;

(e) services provided by a specialist in the field of nutrition or the administration of chemotherapy;

(f) homemaker services; and

(g) maintenance or personal care services.

ADULT DAY CARE BENEFITS

If you receive adult day care from an adult day care center, we will pay the expense you incur for covered services, up to the Home Health Care Maximum Monthly Benefit for each month you receive such services. *Covered services* for adult day care consist of adult day care center services and fees charged for transportation to and from the adult day care center. Adult day care benefits begin after you have satisfied the policy's *elimination period*.

ASSISTED LIVING FACILITY BENEFITS

If you are confined in an assisted living facility, we will pay the expense you incur for covered services, up to the Assisted Living Facility Maximum Monthly Benefit for each month you are confined. Assisted living facility benefits begin after you have satisfied the policy's *elimination period*. *Covered services* for assisted living facility confinement consist of room and board for a one-bedroom unit, ancillary services, and patient supplies provided by the assisted living facility for care of its residents.

ASSISTED LIVING FACILITY BED RESERVATION BENEFIT

If you are absent for any reason (except discharge) during an assisted living facility confinement, and are charged by the facility to reserve your place there, we will pay an assisted living facility bed reservation benefit up to the calendar year maximum. This assisted living facility bed reservation benefit begins after you have satisfied the policy's *elimination period*.

NURSING HOME BENEFITS

If you are confined in a nursing home, we will pay the expense you incur for covered services, up to the Nursing Home Maximum Monthly Benefit for each month you are confined. Nursing home benefits begin after you have satisfied the policy's *elimination period*. *Covered services* for nursing home confinement consist of room and board, ancillary services, and patient supplies provided by the nursing home for care of its residents.

NURSING HOME BED RESERVATION BENEFIT

If you are absent for any reason (except discharge) during a nursing home confinement, and are charged by the facility to reserve your place there, we will pay a nursing home bed reservation benefit up to the calendar year maximum. This nursing home bed reservation benefit begins after you have satisfied the policy's *elimination period*.

RESPITE CARE BENEFITS

If your unpaid caregiver needs short-term relief from the duties of providing care to you, we will pay the expense you incur for *covered services* for respite care up to the Respite Care Benefit Limit for that calendar year. You do not need to satisfy the *elimination period* in order to use respite care benefits. *Covered services* for respite care consist of home health care, adult day care, confinement in an assisted living facility, or confinement in a nursing home.

HOSPICE CARE BENEFITS

If you are terminally ill and receive hospice care, we will pay the expense you incur for *covered services* up to the applicable maximum monthly benefit for each month you receive such services. The maximum monthly benefit will depend on the location where you receive the hospice care.

You can receive hospice care:

(a) at home as a home health care benefit;

(b) at an adult day care center as an adult day care benefit;

(c) while confined in an assisted living facility as an assisted living facility benefit;

(d) while confined in a nursing home as a nursing home benefit; or

(e) while confined in a hospice care facility.

During confinement in a stand-alone hospice care facility, *covered services* are paid as a nursing home benefit.

You do not need to satisfy the *elimination period* to use hospice care benefits.

INTERNATIONAL BENEFIT

If you meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements while outside of the United States, its possessions or territories, Canada, or the United Kingdom, we will pay a fixed indemnity benefit for each month of:

(a) confinement in a nursing home;

(b) confinement in an assisted living facility;

(c) home health care;

(d) adult day care;

(e) respite care; and

(f) hospice care.

The international benefit is a fixed indemnity benefit equal to the maximum monthly benefit shown on the policy schedule. We will pay the benefit regardless of the actual expenses you incur.

International benefits for nursing home, assisted living facility, adult day care, or home health care begin after you have satisfied the policy's *elimination period*. You do not need to satisfy the *elimination period* to receive hospice care or respite care.

We will pay the international benefit in place of any other policy or rider benefit. The following benefits are not available when you are receiving the international benefit: the Cash Benefit Rider, the care coordinator service, waiver of premium, and stay-at-home benefits.

STAY-AT-HOME BENEFITS

Stay-at-home benefits are only available when you use the care coordinator service.

Stay-at-home benefits are provided to help you remain in your home or return home after a confinement. The care coordinator must determine that stay-at-home benefits are a cost-effective alternative to benefits otherwise provided by the policy. When you follow the plan of care developed by the care coordinator, we will pay the expense you incur for *covered services* for the following stay-at-home benefits:

(a) caregiver training;

(b) durable medical equipment;

(c) home modification; and

(d) medical alert system.

You do not need to satisfy the *elimination period* to receive stay-at-home benefits. However, you cannot use stay-at-home benefits to satisfy the *elimination period* for other policy benefits. All four stay-at-home benefits combined are subject to the single Stay-At-Home Benefit Limit.

ALTERNATE CARE BENEFIT

Alternate care benefits are only available when you use the care coordinator service.

When a plan of care developed by a care coordinator recommends treatment, services, or supplies not otherwise covered by the policy, we may pay benefits for such alternate types of care if:

(a) they are qualified long-term care services;

(b) they are a less-expensive alternative to the policy's other benefits for which you are then eligible; and

(c) you, we, and a licensed health care practitioner agree to the alternate care services in writing.

We will not pay an alternate care benefit for any benefit that was available or for which you were ineligible at the time of application.

CASH BENEFIT

If you meet the policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, you may elect to receive a monthly cash benefit in place of any other benefit for which you qualify under the policy. The cash benefit is a fixed indemnity benefit that we will pay in advance, at the start of each month, regardless of the actual expenses you incur. We reserve the right to require an assessment and a new plan of care at least once every 90 days while you are receiving the cash benefit.

You do not need to satisfy the policy's *elimination period* to receive the cash benefit. However, any days on which you receive the cash benefit cannot be used to satisfy the *elimination period* for other policy benefits. If you switch from the cash benefit to another policy benefit, you must still satisfy the *elimination period* applicable to the other policy benefit.

We will not pay the cash benefit if you are located outside of the United States, its possessions or territories, Canada, or the United Kingdom at the time you are eligible for the cash benefit.

CONTINGENT NONFORFEITURE BENEFIT

The contingent nonforfeiture benefit is available to you if there is a substantial premium increase for your coverage. This benefit allows you to choose either a reduced benefit amount to prevent premium increases, or to convert your policy to a paid-up status.

If you convert your coverage to paid-up status, you will not be required to make further premium payments, and we will continue to pay benefits up to the applicable monthly maximums. However, your policy limit will be reduced to an amount equal to the greater of: (a)the maximum monthly benefit in effect on the date your policy lapsed; or (b) the total amount of premiums paid for your policy.

The reduced policy limit will not exceed the policy limit amount remaining in effect on the date the policy lapsed.

OTHER NONFORFEITURE BENEFIT

NONFORFEITURE BENEFIT - SHORTENED BENEFIT PERIOD

The optional Nonforfeiture Benefit - Shortened Benefit Period provides a continuation of your coverage, but with a reduced policy limit, if your coverage lapses on or after the third policy anniversary date. We will continue to pay benefits up to the applicable monthly maximums. However, the policy limit will be reduced to an amount equal to the greater of: (a) the maximum monthly benefit in effect on the date the policy lapsed; or (b) the total amount of premiums paid for the policy. The reduced policy limit will not exceed the policy limit amount remaining in effect on the date the policy lapsed.

OPTIONAL BENEFITS

You may elect any of the following options to expand the benefits under the policy:

PROFESSIONAL HOME HEALTH CARE BENEFITS

If you receive professional home health care from a home health care agency or an independent provider, we will pay the expense you incur for covered services, up to the Professional Home Health Care Maximum Monthly Benefit for each month you receive such services. If the expense you incur for professional home health care exceeds the Professional Home Health Care Maximum Monthly Benefit, we will pay for such expense under the terms of your policy's home health care benefits up to the Home Health Care Maximum Monthly Benefit. Professional home health care benefits begin after you have satisfied your policy's *elimination period*.

Covered services for professional home health care consist of: (a) part-time or intermittent skilled services provided by a nurse (for a maximum of 365 days of service during the life of your policy); (b) physical therapist services; (c) respiratory therapist services; (d) occupational therapist services; (e) speech therapist services; (f) audiologist services; (g) chemotherapy administration specialist services; and (h) nutritional specialist services.

WAIVER OF ELIMINATION PERIOD FOR HOME HEALTH CARE BENEFIT

This feature waives the requirement that you satisfy the *elimination period* before we will pay home health care or adult day care benefits. Days on which we waive the elimination period for home health care or adult day care benefits will be used to satisfy the elimination period for other benefits available under your policy, including but not limited to nursing home benefits or assisted living facility benefits.

JOINT WAIVER OF PREMIUM

We will waive the payment of your premium when your partner qualifies for the waiver of premium benefit under his or her policy. We will waive your premium for as long as your partner's premium continues to be waived. This waiver of premium benefit is only available if both you and your partner are covered under separate, in-force Mutual of Omaha Insurance Company long-term care policies, series LTC13, and each of you has elected this rider. If we increase your premium because you purchase additional coverage after the policy effective date, such as an increased level of inflation protection, you must pay the amount of the increase until the 10th anniversary of the effective date of the increase. Once waiver of premium ends, you must resume paying premiums to keep the policy in force.

SURVIVORSHIP BENEFIT

If your partner dies after the qualification period expires, your premium will be waived so that no further premium payments will be due for the policy, effective on the next policy renewal date. This survivorship benefit is only available if both you and your partner are covered under separate, in-force Mutual of Omaha Insurance Company long-term care policies, series LTC13, each of you has this rider in force, and both of you continue to live for the length of the qualification period. If we increase your premium because you purchase additional coverage after the policy effective date, such as an increased level of inflation protection, you must pay the amount of the increase until the 10th anniversary of the effective date of the increase.

SHARED CARE BENEFIT

If your policy limit has been reduced to zero, this rider allows you to draw from your partner's policy limit to pay for benefits that you qualify for under your policy. The shared care benefit is only available if both you and your partner have identical coverage, including the shared care benefit, in force. If your partner dies while this benefit is in force, the remaining amount of your partner's policy limit will be added to your policy limit. Your partner may receive benefits under his or her policy at the same time that you are drawing on your partner's policy limit.

SECURITY BENEFIT

If you are receiving benefits under your policy, and your partner is alive, we will pay you an additional cash benefit, which is a percentage of the monthly benefit for *covered services* you receive. We will not pay the security benefit if you are receiving benefits under any Cash Benefit Rider that may be a part of your policy.

RETURN OF PREMIUM BENEFITS

Payment of any return of premium benefit will not include interest, any benefits paid under your policy, any waived premiums, or any unearned premium that we refund.

RETURN OF PREMIUM AT DEATH BENEFIT

This return of premium benefit provides for a refund of premiums, minus all benefits paid, if you die while the policy is in force.

RETURN OF PREMIUM IF DEATH OCCURS BEFORE AGE 65 BENEFIT

This return of premium benefit provides for a refund of premiums, minus all benefits paid, if you die while the policy is in force but prior to the policy anniversary date coinciding with or next following your 65th birthday.

THREE TIMES THE MAXIMUM MONTHLY BENEFIT RETURN OF PREMIUM AT DEATH BENEFIT

This return of premium benefit provides for a refund of premiums, minus all benefits paid, if you die while the policy is in force, but no more than three times your maximum monthly benefit. For the purposes of this rider, the maximum monthly benefit is the lesser of your initial maximum monthly benefit, or your most recent maximum monthly benefit, excluding the whole amount of any inflation protection increases. The policy must remain in force for the length of the 10 year qualification period.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for the payment of benefits under all provisions of the policy:

(a) You must be *chronically ill*; and

(b) We must receive a written plan of care from a licensed health care practitioner prescribing qualified long-term care services.

Chronically ill means (a) you are unable to perform at least two *activities of daily living* without substantial assistance from another person who is physically present with you, for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or (b) you require substantial supervision to protect yourself from threats to health and safety due to a severe cognitive impairment.

You will only meet the definition of *chronically ill* if, within the preceding 12 months, a licensed health care practitioner has certified that you meet such requirements.

Activities of daily living means the following self-care functions: bathing, continence, dressing, eating, toileting, and transferring.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

You must meet **ALL** of the following conditions to be eligible for benefits:

(a) The policy must be in force on the date for which you are claiming benefits.

(b) The policy limit has not been reduced to zero.

(c) You have not exhausted any maximum benefit amount that applies to the benefit you are claiming.

(d) You must satisfy the *elimination period* if it applies to the benefit you are claiming. The *elimination period* does not apply to the Cash Benefit Rider, if part of your coverage, respite care benefits, hospice care benefits, stay-at-home benefits, and the care coordinator service.

ONE BENEFIT IS PAYABLE ON A SINGLE DAY

If you are eligible for benefits under more than one provision on any single day, we will pay benefits under the provision which pays the greatest amount. This limitation applies even if multiple benefits share the same maximum benefit amount. This limitation does not apply to the policy's stay-at-home benefits, which you may receive at the same time as other policy benefits. The monthly cash benefit may be paid in place of any other benefit if the Cash Benefit Rider is part of your coverage.

10. LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

(a) services provided by an immediate family member, unless:

1. he or she is a regular employee of the facility or agency providing the covered services;
2. the facility or agency receives the payment for the covered services; and
3. he or she receives no compensation other than the normal compensation for employees in his or her job category;

(b) services for which no charge is made in the absence of insurance;

(c) services provided outside of the United States, its possessions or territories, Canada, or the United Kingdom (except as provided by the INTERNATIONAL BENEFIT section);

(d) loss resulting from suicide, attempted suicide, or intentionally self-inflicted injury;

(e) loss resulting from alcoholism or drug addiction (except for an addiction to a prescription medication when administered in accordance with the advice of your physician);

(f) treatment provided in a government facility (unless otherwise required by law) except a Veterans Administration facility;

(g) services received while the policy is not in force (except as provided by the EXTENSION OF BENEFITS section); or

(h) loss resulting from war or act of war (declared or undeclared).

NON-DUPLICATION OF BENEFITS

We will not duplicate benefits for that portion of covered expense paid or payable:

(a) by Medicare, including amounts that are reimbursable or would be reimbursable but for the application of a deductible or coinsurance amount;

(b) by any other governmental program (except Medicaid), including the Veterans Administration; or

(c) by any state or federal workers' compensation, employer liability, or occupational disease law, or any motor vehicle no-fault law.

THE POLICY MAY NOT COVER ALL EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. THE RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. You may elect one of the inflation protection options to increase your coverage. Only increases taken in accordance with one of the inflation protection options do not require proof of insurability.

COMPOUND INFLATION PROTECTION - LIFETIME BENEFIT

The optional Compound Inflation Protection - Lifetime Benefit increases the benefit amounts of the policy each year. On each policy anniversary date, we will increase the policy limit and your then existing maximum monthly benefit by the increase percentage you select on the application. Your premium will not change solely because of these annual benefit increases.

COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT

The optional Compound Inflation Protection - Limited Period Benefit increases the benefit amounts of the policy as follows: On each policy anniversary date for the remainder of the limited period you selected, we will increase the policy limit and your then existing maximum monthly benefit by the increase percentage you selected on the application. Benefit increases will stop accruing after the number of years in the limited period have expired. Your premium will not change solely because of these annual benefit increases.

COMPOUND INFLATION PROTECTION BENEFIT WITH BUY-UP OPTION

The optional Compound Inflation Protection Benefit with Buy-Up Option increases the benefit amounts of the policy each year. On each policy anniversary date, we will increase the policy limit and your then existing maximum monthly benefit by the increase percentage you select on the application. Your premium will not change solely because of these annual benefit increases. However, your premium will increase if you elect the buy-up option. The increase will be based on your age and the premium rate in effect for the new compound inflation percentage at that time.

BUY-UP OPTION

On or before each policy anniversary date, you may choose to increase your compound inflation percentage to any percentage we offer. Your total level of inflation protection cannot exceed 5%. You are eligible for the Buy-Up Option unless, at any time during the two years preceding your request to exercise this option: we waived premium under any provision of the policy; the policy was paid-up; or you were *chronically ill*.

Premium for the policy will increase each time you elect the buy-up option. Benefit increases will not occur until the second policy anniversary date coinciding with or next following the date your written request is received and accepted by us.

COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT WITH BUY-UP OPTION

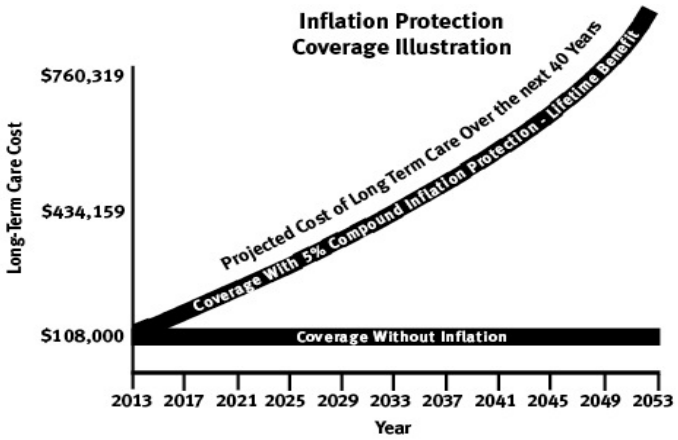
The optional Compound Inflation Protection – Limited Period Benefit with Buy-Up Option increases the benefit amounts of the policy as follows: On each policy anniversary date for the remainder of the limited period you selected, we will increase the policy limit and your then existing maximum monthly benefit by the increase percentage you select on the application. Benefit increases will stop accruing after the number of years in the limited period have expired. Your premium will not change solely because of these annual benefit increases. However, your premium will increase if you elect the buy-up option. The increase will be based on your age and the premium rate in effect for the new compound inflation percentage at that time.

BUY-UP OPTION

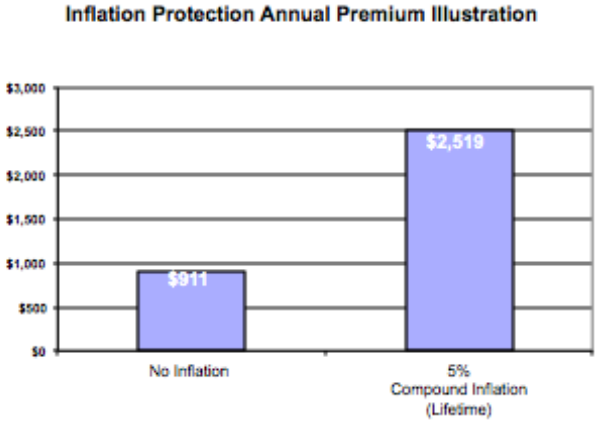
On or before each policy anniversary date, you may choose to increase your compound inflation percentage to any percentage we offer. Your total level of inflation protection cannot exceed 5%. You are eligible for the Buy-Up Option unless, at any time during the two years preceding your request to exercise this option: we waived premium under any provision of the policy; the policy was paid-up; or you were *chronically ill*.

Premium for the policy will increase each time you elect the buy-up option. Benefit increases will not occur until the second policy anniversary date coinciding with or next following the date your written request is received and accepted by us.

INFLATION PROTECTION – GRAPHIC COMPARISON



The Inflation Protection – Graphic Comparison shows the anticipated cost for one year of institutional care during a 40-year period and compares the policy limit for two types of coverage: one with a 5% Compound Inflation Protection - Lifetime Benefit and one without inflation protection.



The Inflation Protection Annual Premium Illustration compares the annual premium paid by a 63-year old male, in the Select underwriting class, for two types of coverage: one with a 5% Compound Inflation Protection - Lifetime Benefit and one without inflation protection, assuming the following coverage features:

- a 3-year benefit at $3000/month ($3000 times 36 months = $108,000 policy limit);
- $3000/month Nursing Home MMB;
- $3000/month Assisted Living Facility MMB;
- $3000/month Home Health Care MMB; and
- an *elimination period* of 90 days.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application is approved, the policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

13. PREMIUM

Refer to the table below to find the annual premium.

PREMIUM

Premium Payment Mode (Adjustment Factor) Limited Pay - Complete below.

❒ Annual (1.0) ❒ Semi-Annual (.51)
❒ Quarterly (.26) ❒ Monthly Electronic Funds Transfer (.09)

Basic Policy Coverage Premium:	$
Nonforfeiture Benefit - Shortened Benefit Period:	$
Compound Inflation Protection Selected:	$
Professional Home Health Care:	$
Return of Premium at Death Benefit Selected:	$
Security Benefit:	$
Shared Care Benefit:	$
Joint Waiver of Premium Benefit:	$
Survivorship Benefit:	$
Waiver of Elimination Period for Home Health Care Benefit:	$
Total Annual Premium:	$
Modal Premium:	$
(Annual X Mode Factor)	

14. ADDITIONAL FEATURES

UNDERWRITING

We require medical underwriting when you apply for coverage.

PROTECTION AGAINST UNINTENTIONAL LAPSE

You have the right to designate at least one person who is to receive notice of lapse due to non-payment of premium in addition to yourself. If the policy lapses due to non-payment of premium, we will reinstate the policy if we receive proof that you were *chronically ill* beginning on or before the date of lapse. We must receive your request for reinstatement within five months of the date of lapse and you must pay all past due premiums.

15. CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.

LONG-TERM CARE INSURANCE

Preparing for the Personal Health Interview

WHAT IS THE PERSONAL HEALTH INTERVIEW?

Completing a personal health interview is your next step in applying for a long-term care insurance policy. The interview – typically conducted by a registered nurse – is used to assess your eligibility for long-term care insurance.

HOW IS THE INTERVIEW CONDUCTED?

Once we are in receipt of your application we will contact you to schedule a time to complete a telephone or in-person interview.

- If you are age 64 or younger, the interview will be conducted over the telephone and take approximately 30-45 minutes to complete. It may be completed at the time of the initial call if both you and an interviewer are available. If that time is not convenient, another time can be scheduled. Please make sure that the interview time is convenient for you and that you will be free of distractions.
- If you are age 65 or older or you have certain medical conditions, a nurse will come to your home to meet with you in person. This will take approximately one hour. A nurse will contact you to schedule the interview at your convenience. (Home means your primary residence, owned vacation home or owned 2nd residence.)
- We will make every attempt to try and contact you within the two hour window specified on the application. For example, if you indicate 5:00pm, the contact window is from 5:00-7:00pm. The time zone will reflect the legal residence address you have indicated on your application.

WHAT QUESTIONS WILL I BE ASKED?

We will ask you a series of questions about your current health, the medications you take and your daily activities. Questions also will be asked to evaluate your memory and mental ability. The questions are not difficult, and will include things like:

- The name of your primary care physician and any specialists you see
- The names of the medications you take
- Your future plans for surgery, medical testing or medical consultation
- Your living arrangements and social activities
- Your use of medical devices, such as a wheelchair

WHY IS THE INTERVIEW SO IMPORTANT?

The information you provide will be used to determine if you are eligible for a long-term care insurance policy. For that reason, it's important to give the interviewer your full attention and answer all questions completely and accurately.

- Turn off the television or radio
- Move to a quiet spot where you will not be distracted
- Make sure you can hear the interviewer clearly
- Answer all questions to the best of your ability
- If a distraction should occur while the interview is being conducted, please let the nurse know and ask to reschedule at a better time

YOUR INFORMATION IS STRICTLY CONFIDENTIAL

We protect your privacy by safeguarding the information you provide. Mutual of Omaha will not share your medical information, except to the extent we are required or permitted to under federal or state law.

M26798

M26798

Use this form to prepare for the personal health interview

Take a few minutes now to collect the following information so you'll be prepared for your personal health interview.

Applicant A	Applicant B

Primary Care Physician

Name: _____ Name: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone Number: _____ Phone Number: _____

Date/Reason Last Seen: _____ Date/Reason Last Seen: _____

Specialist

Name: _____ Name: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone Number: _____ Phone Number: _____

Date/Reason Last Seen: _____ Date/Reason Last Seen: _____

Current Medications (prescription and over-the-counter)

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____