

MUTUAL OF OMAHA INSURANCE COMPANY

APPLICATION for INDIVIDUAL LONG-TERM CARE

GEORGIA

MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

MAP318_GA

LONG-TERM CARE INSURANCE

Personal Worksheet

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

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) LTC09M Type of Policy: Guaranteed Renewable Noncancellable Single Premium

Applicant A

The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year or a one-time single premium of \$_____

Applicant B

The premium for the coverage you are considering will be \$_____ per month, or \$_____ per year or a one-time single premium of \$_____

The Company's Right to Increase Premiums

The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state. Once your policy is paid up, the company cannot raise your rates.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2009. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	Rate History
NH23/NH24	1987 - 1993	No Rate Increase
LTC1/LTM1	1992 - 1997	No Rate Increase
LT50/NH50	1997 - 2004	No Rate Increase
NHA/LTA/HCA	1998 - 2004	23% overall rate increase 2003
LTC04I	2004 - 2009	No Rate Increase
LTC04I7	2006 - 2009	No Rate Increase
LTC09M	2009 - Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

Questions Related to Your Income

Applicant A

1. How will you pay each year's premium? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay
2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.
3. What is your annual income? (Check one)
- Under \$16,000
 \$16,000 and over
4. How do you expect your income to change over the next 10 years? (Check one)
- No Change Increase Decrease

Applicant B

1. How will you pay each year's premium? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay
2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.
3. What is your annual income? (Check one)
- Under \$16,000
 \$16,000 and over
4. How do you expect your income to change over the next 10 years? (Check one)
- No Change Increase Decrease

If you will 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 7% of your income.

5. Will you buy inflation protection? (Check one)
- Yes No
- If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

5. Will you buy inflation protection? (Check one)
- Yes No
- If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

The national average annual cost of nursing home care in 2008 was \$64,605, but this figure varies across the country. In ten years the national average annual cost would be about \$105,234 if costs increase 5% annually.

6. What elimination period are you considering?
- Number of days _____
- Approximate cost \$_____ for that period of care.

6. What elimination period are you considering?
- Number of days _____
- Approximate cost \$_____ for that period of care.

Multiply the number of days with daily average for approximate cost of care. Reference cost of care sheet for state averages.

7. How are you planning to pay for your care during the elimination period? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

7. How are you planning to pay for your care during the elimination period? (Check one)
- From my Income
 From my Savings/Investments
 My Family will Pay

Questions Related to 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)
- Under \$50,000
 \$50,000 and over
2. How do you expect your assets to change over the next 10 years? (Check one)
- Stay about the same Increase Decrease

Applicant B

1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)
- Under \$50,000
 \$50,000 and over
2. How do you expect your assets to change over the next 10 years? (Check one)
- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets, not counting your home, are less than \$50,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Applicant A

(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.

Applicant B

(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.

Applicant A

◀ THIS BOX MUST BE CHECKED

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**



X

Signature of Applicant A

Date

Applicant B

◀ THIS BOX MUST BE CHECKED

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**



X

Signature of Applicant B

Date

I explained to the applicant(s) the importance of completing this information.

Printed Name of Producer



X

Signature of Producer

Date

Authorization to Proceed when Income less than \$16,000 or Assets less than \$50,000

Applicant A

My producer has advised me that this policy does not 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 policy does not seem to be suitable for me. However, I still want the company to consider my application.



X

Signature of Applicant B

Date



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**

If Sponsored/Association, List Name and Service Group Number _____

Section A		GENERAL INFORMATION	
Applicant A		Applicant B	
1 Name:	1 Name:	1 Name:	1 Name:
_____	_____	_____	_____
Last Name	Last Name	_____	_____
_____	_____	_____	_____
First Name	Middle Initial	First Name	Middle Initial
2 Legal Residence Address:	2 Legal Residence Address (If Different than Applicant A):	2 Legal Residence Address (If Different than Applicant A):	2 Legal Residence Address (If Different than Applicant A):
_____	_____	_____	_____
Number, Street, Apartment Number	Number, Street, Apartment Number	_____	_____
_____	_____	_____	_____
City, State, ZIP Code	City, State, ZIP Code	_____	_____
3 Contact Information:	3 Contact Information (If Different than Applicant A):	3 Contact Information (If Different than Applicant A):	3 Contact Information (If Different than Applicant A):
() – () –	() – () –	() – () –	() – () –
Daytime Phone Number	Evening Phone Number	Daytime Phone Number	Evening Phone Number
: a.m.	: p.m.	: a.m.	: p.m.
Best Time to Call	Best Time to Call	Best Time to Call	Best Time to Call
_____	_____	_____	_____
E-mail Address	E-mail Address	E-mail Address	E-mail Address
4 Social Security Number:	4 Social Security Number:	4 Social Security Number:	4 Social Security Number:
□□□□–□□–□□□□□□	□□□□–□□–□□□□□□	□□□□–□□–□□□□□□	□□□□–□□–□□□□□□
5 Birth Date, Age and Gender:	5 Birth Date, Age and Gender:	5 Birth Date, Age and Gender:	5 Birth Date, Age and Gender:
□□□□/□□□□/□□□□□□□□	□□□□/□□□□/□□□□□□□□	□□□□/□□□□/□□□□□□□□	□□□□/□□□□/□□□□□□□□
Month	Day	Year	Age
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Female
6 Occupation and Duties:	6 Occupation and Duties:	6 Occupation and Duties:	6 Occupation and Duties:
_____	_____	_____	_____
Occupation	Occupation	Occupation	Occupation
_____	_____	_____	_____
Occupational Duties	Occupational Duties	Occupational Duties	Occupational Duties

Section A

GENERAL INFORMATION (continued)

Applicant A

Applicant B

7 U.S. Citizenship:

Are you a citizen of the United States? Yes No

If **"No,"** do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____

and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

7 U.S. Citizenship:

Are you a citizen of the United States? Yes No

If **"No,"** do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?

Yes. Card Number _____

and Date of Arrival in the U.S. _____

No. You are not eligible for this coverage.

8 Beneficiary:

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to you

8 Beneficiary (If Different than Applicant A):

First Name, Middle Initial, Last Name

Number, Street, Apartment Number

City, State, ZIP Code

Relationship to you

Section B

ALLOWANCES

You may be eligible for allowances based on your answers to the following questions in this Section B.

1 Are you married?
Do you have a Domestic Partner*?
If **"No,"** go to question 2. If **"Yes,"**:
(a) Is your Spouse or Domestic Partner also applying for this coverage?
If **"Yes,"** provide name
(b) Does he/she have an existing Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company long-term care policy/certificate?
If **"Yes,"** provide existing long-term care policy/certificate number(s)

2 Are you single and have you been continuously residing with another person for the last 12 months and are they also applying for this coverage?
If **"Yes,"** provide name

3 Do you have or are you applying for a Medicare Supplement policy/certificate with Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?
If **"Yes,"** provide existing policy/certificate number(s)

4 Are you a member, or qualified family member, of a Sponsored/Association group endorsing this long-term care product?
If **"Yes,"** provide Sponsored/Association Service Group Number _____
Full Name of Organization _____
Name and Relationship to Member _____

Applicant A		Applicant B	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Domestic Partner means a person of the same sex who lives with you in a domestic partner relationship and who meets all criteria on a Declaration of Domestic Partnership Form provided by us. You and your Domestic Partner must submit an accurate and completed Declaration of Domestic Partnership Form, and meet all the criteria listed on the form. Continued eligibility of your Domestic Partner is contingent upon the continuing accuracy of the Declaration. Domestic Partner coverage will cease on the date a Domestic Partner no longer meets such criteria.

Section C

REPLACEMENT COVERAGE

Provide Replacement Coverage Information.

		Applicant A		Applicant B	
		Yes	No	Yes	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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Did you have another long-term care insurance policy/certificate in force during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____/_____/_____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____/_____/_____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> A <input type="checkbox"/> B				\$	<input type="checkbox"/> Pending <input type="checkbox"/> In Force <input type="checkbox"/> Terminated <input type="checkbox"/> Lapsed Ending Date _____/_____/_____	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

				Applicant A		Applicant B	
				Yes	No	Yes	No
6	Have you ever been declined, rated, or denied reinstatement for long-term care insurance?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," provide details below. (Attach additional signed page(s) if more space is needed.)							
Applicant	Company Name(s)	When	Why				
<input type="checkbox"/> A <input type="checkbox"/> B							
<input type="checkbox"/> A <input type="checkbox"/> 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: <ul style="list-style-type: none"> • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Within the past 6 months have you been confined to, or been advised to have, any of the following: <ul style="list-style-type: none"> • residential care, assisted living or adult day care facility services • nursing home or home health care services • physical, occupational or speech therapy 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you require the assistance or supervision of another person or a device of any kind for any of the following: <ul style="list-style-type: none"> • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Within the last 10 years, have you been medically diagnosed as having, or received medical advice or medical care from a physician or health care provider for any of the following: <ul style="list-style-type: none"> • Alzheimer’s Disease • Dementia • Memory Loss • Mental Retardation • Schizophrenia • Psychosis • Organ Transplant • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, two or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy or history of 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 • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year • Amyotrophic Lateral Sclerosis (ALS) • Huntington’s Chorea • Kidney Failure or received Dialysis • Parkinson’s Disease • Multiple Sclerosis • Muscular Dystrophy • Chronic Hepatitis • Cirrhosis • Myasthenia Gravis • Paralysis • Scleroderma • Systemic Lupus 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Are you currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers’ compensation, Social Security disability or any federal or state disability plan? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section E

PRIMARY CARE PHYSICIAN INFORMATION AND MEDICATION

1 Provide the name, complete address and phone number of your Primary Care Physician.

	Applicant A	Applicant B (If Different than Applicant A)
Primary Care Physician	_____	_____
Address	_____	_____
City, State, ZIP	_____	_____
Phone Number	_____	_____

2 Date & Reason for Last Visit:	_____
---	-------

3 Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently?... If “Yes,” please list below all the medication name(s) using pharmacy label, dosage/frequency and reason prescribed. (Attach additional signed page(s) if more space is needed.)	Applicant A		Applicant B	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

	Applicant A	Applicant B
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____
Medication Name	_____	_____
Dosage/Frequency	_____	_____
Disease/Disorder/Condition	_____	_____

Section F

ADDITIONAL HEALTH QUESTIONS

	Applicant A		Applicant B	
	Yes	No	Yes	No
1 Within the last 10 years, have you been diagnosed or treated by a physician or health care provider for any of the following conditions?				
Alcohol or Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or Blood Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Back, Bone or Joint Disorder or Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance Disorder, Difficulty Walking or Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or other Mental Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia, Weakness or Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Disorder or High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune System Disease/Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Liver Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, Epilepsy or Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you scheduled for, or have you been advised by a physician or health care provider to have additional testing, surgery or consultation(s) to evaluate your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Are there any pending test results which you have not yet received?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Do you have, for your use, a handicap parking sticker or handicap license plate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Have you used tobacco in any form in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 What is your height?	' "		' "	
9 What is your weight?	lbs		lbs	

Section F

ADDITIONAL HEALTH QUESTIONS (continued)

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

Applicant A

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

Applicant B

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

INSTRUCTIONS: Complete Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – OR – Section H for MUTUAL CARE MY WAY.

INFLATION PROTECTION: You have the option to purchase a 5% Compound Inflation Protection (Lifetime) benefit. Neither MUTUAL CARE 3 nor MUTUAL CARE 5 offer the 5% Compound Inflation Protection (Lifetime) benefit. If you want to purchase this benefit – SKIP Section G and complete Section H for MUTUAL CARE MY WAY. Check the first box in H7.

Section G

MUTUAL CARE 3 – OR – MUTUAL CARE 5

Applicant A

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

1 Select Mutual Care 3 or Mutual Care 5
(must check one):

1 Select Mutual Care 3 or Mutual Care 5
(must check one):

Mutual Care 3

- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

Mutual Care 3

- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

Mutual Care 5

- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

Mutual Care 5

- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

2 Acknowledgement (must check):

◀ I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included: 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) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

2 Acknowledgement (must check):

◀ I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included: 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) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

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

\$, per month
(**\$3,000-\$15,000 in \$500 increments**)

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

\$, per month
(**\$3,000-\$15,000 in \$500 increments**)

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.

OPTIONAL BENEFIT FOR MUTUAL CARE 3 – OR – MUTUAL CARE 5

5 Spouse Shared Care Benefit

Only available when both Spouses or Domestic Partners apply at the same time and both policies are issued with identical benefits.

5

If you completed Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – SKIP Section H and continue to Section I.

Applicant A

8 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.

Applicant B

8 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.

OPTIONAL BENEFITS FOR MUTUAL CARE MY WAY

9 Waiver of Elimination Period for Home Health Care Benefit9 Waiver of Elimination Period for Home Health Care Benefit

10 Spousal Benefits:

The **Spouse Waiver of Premium, Spouse Survivorship Benefit** and **Spouse Shared Care Benefit** are only available when both Spouses or Domestic Partners apply at the same time and both policies are issued.

 Spouse Waiver of Premium Spouse Survivorship Benefit Spouse Shared Care Benefit

The **Spouse Shared Care Benefit** is only available when both policies are issued with identical benefits.

10

11 Spouse Security Benefit

Not available for issue ages 70 and older, with Spousal Benefits or if Spouse or Domestic Partner is applying for this coverage.

Spouse’s or Domestic Partner’s Name

11

12 Restoration of Benefits

Not available with Lifetime Benefits.

12 Restoration of Benefits

Not available with Lifetime Benefits.

13 Additional Benefit for Injury13 Additional Benefit for Injury14 5 Years of Rate Guarantee14 5 Years of Rate Guarantee

15 Return of Premium at Death Benefit:

Return of Premium (Less Claims Paid) If Death Occurs Before Age 65

OR

Return of Premium at Death (Less Claims Paid)

OR

Full Return of Premium at Death

15 Return of Premium at Death Benefit:

Return of Premium (Less Claims Paid) If Death Occurs Before Age 65

OR

Return of Premium at Death (Less Claims Paid)

OR

Full Return of Premium at Death

Continue to Section I.

Section I

PREMIUM INFORMATION

Applicant A

Applicant B

1 Premium Options (must check one):

- Lifetime
- Single Premium
- 10-Year Pay
- 20-Year Pay
- To-Age-65

1 Premium Options (must check one):

- Lifetime
- Single Premium
- 10-Year Pay
- 20-Year Pay
- To-Age-65

2 Premium Amount:

Modal Premium: \$ _____

Premium Collected: \$ _____
- Two Months Minimum

2 Premium Amount:

Modal Premium: \$ _____

Premium Collected: \$ _____
- Two Months Minimum

3 Recurring Premium Mode (check one unless Single Premium):

- Monthly Automatic Checking Account (.09) Deduction
Specify the date premiums will be withdrawn
(1st through the 28th of the month): _____

Bank Name _____

Routing Number

--	--	--	--	--	--	--	--	--	--

Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Or include a voided check.)

3 Recurring Premium Mode (check one unless Single Premium):

- Monthly Automatic Checking Account (.09) Deduction
Specify the date premiums will be withdrawn
(1st through the 28th of the month): _____

Bank Name _____

Routing Number

--	--	--	--	--	--	--	--	--	--

Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

(Or include a voided check.)

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company

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



X

Signature of Applicant A

Date



X

Signature of Applicant B

Date

Direct Bill:

- Quarterly (.26)
- Semiannual (.51)
- Annual (1.0)

Billing Address for Premium Notices
(if different from page 1):

Name

Street Address, Apartment Number

City, State, ZIP Code

Direct Bill:

- Quarterly (.26)
- Semiannual (.51)
- Annual (1.0)

Billing Address for Premium Notices
(if different from page 1):

Name

Street Address, Apartment Number

City, State, ZIP Code

4 Select Effective Date:

- Date of Application
- Date Policy is Issued
- For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

4 Select Effective Date:

- Date of Application
- Date Policy is Issued
- For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

Section J

NOTICE BEFORE LAPSE OR TERMINATION

Please check the applicable box and complete the requested information. You may want to consider designating someone other than a Spouse or Domestic Partner.

Applicant A

- I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.

Name (Print full name of other person to receive notice of lapse or termination)

Street Address, Apartment Number

City, State, ZIP Code

Protection against unintended lapse. 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.

OR

- I elect NOT to designate any person to receive such notice.

Applicant B

- I wish to designate an additional 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)

Street Address, Apartment Number

City, State, ZIP Code

Protection against unintended lapse. 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.

OR

- I elect NOT to designate any person to receive such notice.

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.
3. Applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives any additional information requested for underwriting (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 there is no temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions of the Conditional Receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the 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.
5. Applicant acknowledges that no Producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. Applicant acknowledges receipt of an Outline of Coverage, Shopper’s Guide to 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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Separate policies will be issued to eligible applicant.

Caution: If your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company may have 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	Signed at _____ City State
X Signature of Applicant A Date	X Signature of Applicant B Date

Signed at _____ City State	Signed at _____ City State
X Signature of Applicant A Date	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(s)

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

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

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



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

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

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

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

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

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

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

MLU26722

LONG-TERM CARE INSURANCE

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

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

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 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 which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay 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, waiting periods, elimination periods or probationary periods.


The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent 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

DECLARATION OF DOMESTIC PARTNERSHIP FORM

DOMESTIC PARTNERSHIP STANDARDS

- We share the same primary, regular and permanent residence and have Lived Together for the previous six months;
- We have a committed personal relationship with each other that is mutually interdependent and intended to be lifelong;
- We agree to be jointly obligated and responsible for the Necessities Of Life for each other;
- We are not married to anyone or legally separated from anyone;
- We are each eighteen years of age or older;
- We are competent to enter into a contract;
- We are not related by blood closer than would bar marriage in the State of Georgia;
- We are each other's sole domestic partner;
- We agree to file a termination of Domestic Partnership with the insurer within 30 days if any of the above facts change;
- Any prior domestic partnership in which either of us participated with a third party terminated not less than six months prior to the date of said Declaration, and if such earlier domestic partnership had been acknowledged under provisions of this section, that notice of termination of such earlier domestic partnership was provided to the insurer or state, county, local or municipal department responsible for Domestic Partners registry;
- We agree to promptly inform the insurer of any changes in the status of this Domestic Partnership;
- We hereby make application to register as Domestic Partners pursuant to these terms and conditions.

DEFINITIONS

- **Live Together** means that two people claiming Domestic Partnership share the same primary, regular and permanent residence. It is not necessary that the legal right to possess the residence be in both names. Whether the relationship between these two people is or is not sexual is in no way relevant for the purpose of determining eligibility under this Declaration.
- **Necessities Of Life** means the cost of basic food, shelter, clothing and medical care. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible and obligated for the cost.

We declare under penalty of perjury and insurance fraud under the laws of the State of Georgia that the statements are true and correct.



X

Signature

Printed Name

Social Security Number



X

Signature

Printed Name

Social Security Number

Notarization:
State of Georgia County of _____

On this ____ day of _____ in the year _____ before me personally appeared _____ and _____ known to be (or provided to me on the basis of satisfactory evidence) the persons whose names are subscribed to this instrument, and acknowledged that they executed it on the above date.

(witness)

(Notary Public)

(Seal)

Primary residence address:

City, State and ZIP Code

To complete the registration of this Domestic Partnership, you must:

- File this form with the employer/insurer/administrator;
- Provide two forms of acceptable identification verifying joint residency, (i.e. Georgia Drivers License, Georgia I.D., voter registration, passport with current residency, or utility bill);
- Sign this form in front of a Notary Public and complete the notarization.