United of Omaha Life Insurance Company

Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175

Group Insurance Evidence of Insurability Form

Please print clearly in blue or black ink. All required information should be completed to avoid any delays in the processing of this application. No amount of insurance for which evidence of insurability is required will be effective until approved by the underwriting company. When complete, to help ensure efficient processing and protect your information, mail the completed application to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
P.O. Box 2476
Omaha, NE 68103-2476
Fax: (402)351-2537

Section 1: Policyholder/Employer Information (Required fields are marked with an asterisk (*).)

Policyholder/Employer Name*	**Group ID Number***	**Subgroup Number** (IF APPLICABLE)
	G000 _ _ _ _	

Street Address*	**City***	**State***	**Zip Code**

Section 2: Employee/Member Contact & Employment Information (Required fields are marked with an asterisk (*).)

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

Street Address*	**E-mail Address**

City*	**State***	**Zip Code***	**Telephone*** (XXX)XXX-XXXX

Full-Time Employment Date (MM/DD/YYYY)*	**Annual Salary***	**Job Title/Description***	**Avg. Hours Worked/Week**

Section 3: Applicant (Proposed Insured) Information (Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee/Member is Applying for Insurance

Birth Date (MM/DD/YYYY)*	**State of Birth***	**Gender***	**Weight***	**Height***	**SSN/ID Number**
		☐ F ☐ M	Lbs.	Ft. In.	

Part B – Complete if Applying for Spouse Insurance (for Life Insurance only)

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

Birth Date (MM/DD/YYYY)*	**State of Birth***	**Gender***	**Weight***	**Height***	**SSN/ID Number**
		☐ F ☐ M	Lbs.	Ft. In.	

Note: *Use of the term "spouse" on this application refers to the person to whom you are legally married; or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live.*

Part C– Complete if Applying for Child(ren) Insurance (for Life Insurance only)

Last Name*	**First Name***	**Gender***	**Birth Date** (MM/DD/YYYY)*	**Weight**	**Height**
		☐ F ☐ M		Lbs.	Ft. In.
		☐ F ☐ M		Lbs.	Ft. In.
		☐ F ☐ M		Lbs.	Ft. In.
		☐ F ☐ M		Lbs.	Ft. In.

Note: *If you apply for one child, you must apply for all eligible children. Attach a list of additional children with the above information if necessary.*

Section 4: Requested Insurance

Select each insurance product for which you are applying:

☐ Life ☐ Short-Term Disability (STD) ☐ Long-Term Disability (LTD)

Section 5: Requested Life Insurance Benefit Amount (Required fields are marked with an asterisk (*).)

	Employee/Member (IF APPLICABLE)	**Spouse** (IF APPLICABLE)	**Child(ren)** (IF APPLICABLE)
(1) Current Amount of Insurance (IFANY)			
(2) Additional Requested Amount			
(3) Total Amount of Insurance Requested* (1+2)			

Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance (A response is required for each question for each applicant.)

Part A

1 – During the past 5 years, has any person proposed for insurance ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following (Check all that apply):

Condition	Member	Spouse	Condition	Member	Spouse
Urinary tract or kidney?	☐	☐	Lung or respiratory disorder?	☐	☐
Liver or hepatitis?	☐	☐	Chronic fatigue syndrome?	☐	☐
Anemia or blood (except HIV)?	☐	☐	Arthritis or joints (incl. replacements)?	☐	☐
Skin or connective tissue?	☐	☐	Epilepsy or any nervous, mental or emotional disorder?	☐	☐
Chronic Epstein-Barr?	☐	☐	Breasts or reproductive organs (incl. implants, infertility, irregular cycles, pregnancy complications)?	☐	☐
Cancer or tumor?	☐	☐	Neurological condition (incl. Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)?	☐	☐
Alcohol or drug abuse?	☐	☐	Any disease of the immune system (except HIV)?	☐	☐
Spine, neck or back?	☐	☐	Stroke or cerebral vascular condition?	☐	☐
Fibromyalgia or myalgia?	☐	☐	Diabetes or glandular condition?	☐	☐
High blood pressure, arteries or veins?	☐	☐	Stomach, upper or lower digestive tract?	☐	☐
Coronary arteries of the heart?	☐	☐			

	Member	Spouse
2 – During the past 5 years, has any person proposed for insurance ever been diagnosed or treated (including medication or recommendation for treatment) by a member of the medical profession (for residents of VT, by a licensed physician) for: Acquired Immune Deficiency Syndrome (AIDS); for residents of all states except CO or IN, AIDS Related Complex (ARC); or for residents of all states except CA, IN, ME, NY or VT, Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? **Notice for Residents of CA:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. **Notice for Residents of MN:** The applicant(s) do not have to disclose an HIV (AIDS Virus) test or test to determine a blood-borne pathogen which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility; or (3) to emergency medical service personnel who were tested as a result of performing emergency medical services.	☐ Yes ☐ No	☐ Yes ☐ No
3 – During the past 5 years, other than for questions 1 and 2, has any person proposed for insurance: ▪ Been diagnosed or treated by a medical professional? ▪ Had surgery or been hospitalized? ▪ Had a medical or diagnostic examination or evaluation? ▪ Had or been advised to seek treatment for any illness, injury or disorder (except HIV)? ▪ Received medical care?	☐ Yes ☐ No	☐ Yes ☐ No
4 – Has any person proposed for insurance been absent from work for more than 5 consecutive working days because of illness or injury during the past five years?	☐ Yes ☐ No	☐ Yes ☐ No
5 – Within the past 6 months, has any person proposed for insurance been prescribed medication by a medical professional or taken any medication requiring a prescription?	☐ Yes ☐ No	☐ Yes ☐ No
6 – During the past 5 years, has any person proposed for insurance regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	☐ Yes ☐ No	☐ Yes ☐ No
7 – If female, are you pregnant? If Yes, please provide anticipated delivery date (MM/DD/YYYY): _____	☐ Yes ☐ No	NA

Part B – For any questions (except question 5) in Part A answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format. Attach a separate signed and dated sheet containing additional information if necessary.

Ques. #	Name of Applicant	Date of Occurrence	Date of Recovery	Current Status/ Degree of Recovery	Diagnosis/Condition/Treatment/ Medication/Exam Results	Attending Physician's Name, Address & Phone

Part C – If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable. Attach a separate signed and dated sheet containing additional information if necessary.

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

Section 7: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. If you are a resident of one of these states, please refer to the attached list for the specific fraud warning for your place of residence.)

Section 8: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 8

- **Medical Persons and Entities** means all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of health care services.
- **MIB Group, Inc. (MIB)** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means all health information such as medical history, prescription drug records, mental and physical condition, and drug and alcohol use, and other information such as finances, occupation, general reputation, insurance claims, motor vehicle reports and criminal activity. Personal information does not include psychotherapy notes.
- **Specified Companies** means the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become a part of this group of companies (and their successors), and other persons or entities which act on behalf of said companies to provide services to them.

Part B – Authorization to Disclose Information

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to the underwriting company. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim. For residents of California and Vermont, this authorization excludes the release of any information relating to any previous tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by any person or entity that may possess such information.

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of federal privacy regulations. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by the underwriting company.

Name(s) used for medical records for any proposed insured (if different than the name(s) provided on this form):

_____

Part C – Authorization to Receive and Disclose Information to the MIB

I authorize the MIB to disclose Personal Information for me (the undersigned) to the Specified Companies. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize the Specified Companies to disclose Personal Information for me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom any person proposed for insurance applies for life or health insurance or to whom any proposed insured may submit a claim for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by United of Omaha Life Insurance Company.

Part D – Application for Insurance

I apply for insurance for the proposed insured(s) identified in Section 3 of this application who is/are eligible for insurance. Information in this form is given to obtain the insurance requested and is true and complete, and no important circumstance or information has been withheld or omitted, to the best of my knowledge and belief. I understand that all statements contained in this application for insurance are deemed representations and not warranties.

I understand that insurance for new or additional amounts of insurance in excess of any guarantee issue amount for any proposed insured does not begin until United of Omaha Life Insurance Company approves such person for such amounts, the proposed insured(s) is/are eligible for the insurance under the terms of the policy, and the appropriate premium is paid. If applicable, I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance for any proposed insured.

I understand that this application is only valid for 90 days from my signature date below. I acknowledge that incomplete information on this application may delay processing. If the Specified Companies request additional medical information to complete processing of this application, I understand that any delay in my response may make it necessary for me to submit a new application. I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued to any proposed insured.

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

By signing below, I acknowledge that: (a) I understand and agree to the terms of this application; (b) this form has been completed in accordance with the instructions provided; and (c) for residents of all states except California, I have read the applicable fraud warning for my state of residence.

SIGNATURE OF EMPLOYEE/MEMBER (REQUIRED) _____ **DATE** ____/____/_____

SIGNATURE OF SPOUSE (IFAPPLYING FOR INSURANCE) _____ **DATE** ____/____/_____

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

EMPLOYEE/MEMBER NAME* _____

Section 6 Addendum: Health Information for Life and/or Disability (STD or LTD) Insurance

Part B – For any questions in Part A answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format.

Ques. #	Name of Applicant	Date of Diagnosis	Date of Recovery	Current Status/ Condition	Diagnosis/Condition/Treatment/ Medication/Exam Results/Relationship	Attending Physician's Name, Address & Phone

Part C If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable.

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