APPLICATION for LONG-TERM CARE

United *of* Omaha
Life Insurance Company

COLORADO

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

LONG-TERM CARE
Application Submission Checklist

This application packet includes the application and state vital forms.

Detach and leave with the proposed insured/applicant the indicated forms. The Outline of Coverage(s) and Buyers Guide (not included in this packet) are also to be left with the applicant.

Submit the remainder of the packet intact with every question on the application (of the plan the applicant has selected) and applicable forms completed. Unanswered questions or missing or incomplete forms may/will result in underwriting delays as we attempt to secure the information.

If the 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 C they are ineligible for coverage. Do not submit the application.

Include a copy of your illustration quote with the packet.

Indicate on the application the best time to contact the applicant to schedule the interview and inform them of the telephone interview or face to face interview process. Provide them with a copy of "The Importance of an Accurate Health History."

Premium Payment With Application

If a monthly mode (Bank Draft) is selected we recommend that you collect two months premium to be submitted with the application. If a quarterly, semi-annual or annual mode is elected, the full premium for that mode should be submitted. In order to process the application, a minimum of one month's premium must be submitted with the application, regardless of mode. If full modal premium is not submitted at the time of application, the balance of the premium must be collected on delivery of the policy. New business will not be processed C.O.D. There is no Policy Fee. Applicant checks should be made payable to United of Omaha Life Insurance Company.

Other items to note:

Please check your Agent Guide or Proposal Software for benefit guidelines and maximum benefits.

ADMINISTRATIVE APPENDIX FORMS

Privacy Authorization

Sign and date the form and leave it attached to the application.

Authorization to Withdraw Funds by United of Omaha Life Insurance Company (Monthly Bank Draft)

Complete, sign and date if applicable.
Payments will be deducted monthly on the date specified. Please attach a voided check or deposit slip.
If not provided, account information will be taken from the accompanying premium check.

Association/Employer Sales

Complete only for Association or Franchise Coverage.

Producer Statement

Include your telephone number and email address.
If someone other than you should be contacted for questions regarding the pending application, provide their name, phone number, and email address.

Receipt and/or Temporary Health and Accident Insurance Agreement

Detach and leave with the proposed insured.

Notice of Information Practices

Detach and leave with the proposed insured.

Commission Code	Manager Code	Writing Agent Producer Number
AZ	UNITED	

Mutual of Omaha
United of Omaha Life Insurance Company

Long-Term Care Insurance Application - Individual

Insurance Underwritten By:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Submit Application To:
Long-Term Care Service Office:
P.O. Box 64901
St. Paul, MN 55164-0901

☐ **New Business**
☐ **Reinstatement**
If Group or Association,
List Name _____

A General Questions

Proposed
1 Insured ("You") _____
First Name MI Last Name

☐ Male ☐ Female Date of Birth _____ Age _____
Mo. Day Yr.

Social Security Number _____

2 Legal residence address _____
Number, Street, Apartment Number

_____
City State ZIP Code

Type of Residence ☐ Home ☐ Apartment ☐ Retirement Community ☐ Other _____

3 Phone Number Home _____ Work _____

Best time to call _____a.m. _____p.m. ☐ Home ☐ Work Time Zone _____

4 E-mail address (optional) _____

		Yes	No
5	Are You a U. S. citizen?	☐	☐
	If "No," do You have an Alien Registration Receipt Card (also known as a "Permanent Residence Card" or "Green Card")?	☐	☐
	If "Yes," Card Number _____ Date of arrival in the U. S. _____ (Mo. Yr.)		
	If "No," You are not eligible for this coverage.		
6	Are You married? ☐ Yes ☐ No If "Yes," is Spouse applying for this coverage?	☐	☐
	Are You single, continuously residing in a Two-Person Household for the last 12 months?	☐	☐
	If "Yes," is the other person residing with You applying for this coverage?	☐	☐

Full Name of other Applicant _____
First Name MI Last Name

Social Security Number _____

7 Full Name of Beneficiary _____
First Name MI Last Name

Relationship to You _____

8 Beneficiary's Address _____
Number, Street, Apartment Number

_____
City State ZIP Code

B Other Coverage

		Yes	No
1 **a**	Do You currently have another long-term care policy or certificate in force (including health care service contracts or health maintenance organization contracts)?	☐	☐
b	Did You have another long-term care policy or certificate in force during the last 12 months?	☐	☐
c	Do You intend to replace other long-term care coverage or any of Your medical or health insurance coverage with this policy/certificate? **If "Yes," please read and sign the replacement notice provided by the producer.**	☐	☐

If "Yes" is answered to any question in Section B1 above, provide details below.

Producer must list all health insurance, including long-term care policies, sold to the applicant which: are still in force; or were sold in the last five years but are no longer in force. If "None," check this box ☐.

Company Name/Address	Policy/ Certificate #	Type of Plan	Daily Benefit	Status of Policy/Certificate	Annual Premium	To Be Replaced by this coverage?	Sold by this Producer
			$	☐ Pending ☐ In Force ☐ Not In Force Ending Date / /	$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Pending ☐ In Force ☐ Not In Force Ending Date / /	$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Pending ☐ In Force ☐ Not In Force Ending Date / /	$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Pending ☐ In Force ☐ Not In Force Ending Date / /	$	☐ Yes ☐ No	☐ Yes ☐ No

		Yes	No
2	Have You ever been declined, rated, or denied reinstatement for long-term care insurance?	☐	☐

If "Yes," Name of Company ______________________________

When ______________________________

Why (if known) ______________________________

C Health Insurability Questions

If You answer "Yes" to any of the questions 1 through 13 of Section C below do not continue further. We will be unable to accept this application or offer You Long-Term Care insurance.

		Yes	No
1	Do You currently use any of the following: • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐
2	Within the past 6 months have You been confined to a • residential care facility • assisted living facility • adult day care facility • nursing home	☐	☐
3	Within the past 6 months have You been advised to have • physical therapy • occupational therapy • speech therapy • home health care services	☐	☐
4	Do You require the assistance or supervision of another person or a device of any kind for any of the following: • bathing • toileting • dressing • getting in and out of a chair or bed • eating • Your inability to control Your bowel or bladder • medication management	☐	☐
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	Are You scheduled for an upcoming surgery requiring general anesthesia, or have You been advised to have surgery requiring general anesthesia and not done so?	☐	☐
7	Do You have Diabetes and have numbness or tingling in Your feet, foot ulcers, an amputation, diabetic eye disease, kidney disease, or take more than 50 units of insulin per day?	☐	☐
8	Do You have Diabetes and have You ever had a Stroke/Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA)?	☐	☐
9	Have You ever had, been diagnosed as having, or received medical care for, any of the following: • Alzheimer's Disease • Chronic Hepatitis • Amyotrophic Lateral Sclerosis (ALS) • Dementia • Cirrhosis • Huntington's Chorea • Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis • Mental Retardation • Parkinson's Disease • Paralysis • Schizophrenia • Multiple Sclerosis • Scleroderma • Psychosis • Muscular Dystrophy • Systemic Lupus • Amputation due to disease • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past 12 months	☐	☐
10	Have You ever had two or more Strokes/CVA's or TIA's, have weakness or loss of function from a previous Stroke/CVA or TIA, or have had a single Stroke/CVA in the past 2 years?	☐	☐
11	In the past 2 years have You been diagnosed with Cancer or received treatment for Cancer? (Except basal and squamous cell skin cancers; stage I/A breast, bladder, prostate or thyroid cancers.)	☐	☐
12	Have You ever had an Organ Transplant?	☐	☐
13	Are You currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, worker's compensation, social security disability, or any federal or state disability plan?	☐	☐

If You answered "No" to every question in Section C above, please continue.

D Medication and Physician Information

		Yes	No
1	Are You taking or have You taken any prescription medications within the past 12 months?	☐	☐
2	Are You taking or have You taken any over-the-counter medication(s) on a daily or weekly basis within the past 12 months?	☐	☐

If "Yes" is answered to either question 1 or 2, please list the medication and the following information.

Medication Name (copy from pharmacy label)	Dosage	Frequency	Disease/Disorder/Condition

3 Height _____ (Feet and Inches) Weight _____ (Pounds)

4 Name of Primary Physician _____

Address of Primary Physician _____

_____

Phone Number of Primary Physician _____

Date of Last Visit _____ Reason for Last Visit _____

HMO Patient Number (if Applicable) _____

Have You seen this or any other physician in the last 2 years? ☐ Yes ☐ No

E Health Questions

		Yes	No
1	Do You have, or have You ever received any advice, treatment or consultation from a physician or health care provider for:	☐	☐

Check all that You are answering as Yes –

☐ Stroke or Transient Ischemic Attack	☐ Cancer	☐ Fibromyalgia
☐ High Blood Pressure	☐ Vision Disorder	☐ Osteoporosis
☐ Circulatory Disease/Disorder	☐ Diabetes	☐ Broken Bones
☐ Heart Disease/Disorder	☐ Depression/Other Mental Disorder	☐ Falls
☐ Respiratory Disease/Disorder	☐ Seizures, Epilepsy, Tremors	☐ Dizziness or Fainting
☐ Kidney or Liver Disease/Disorder	☐ Neurological Disease/Disorder	☐ Balance Disorder or Difficulty Walking
☐ Immune System Disease/Disorder	☐ Bowel or Bladder Disease/Disorder	☐ Weakness or Fatigue
☐ Anemia or Blood Disease/Disorder	☐ Arthritis, Bone or Joint Disorder	☐ Alcohol or Drug Use

2	Have You received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?	☐	☐
3	Are You scheduled for, or have You been advised by a physician or health care provider to have additional testing or consultation(s) to evaluate Your health?	☐	☐
4	Are there any pending test results which You have not yet received?	☐	☐
5	Have You been seen by Your physician, health care provider or any specialists more than three times in the past 12 months?	☐	☐
6	Have You obtained a handicap sticker or handicap license plate?	☐	☐

Provide details below for all questions answered "Yes" in this Section E:

Disease/Disorder/Condition	Date of Occurrence/ Date of Last Visit	Physician/Facility Information
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #
		Name Address Phone #

F Assured Solutions Benefit Selection

Assured Solutions

☐ **Tax Qualified** ☐ **Non-Tax Qualified**

Maximum Daily Benefit	Nursing Home (NH)	$ _____ per day ($50-$500, in $10 increments)
	Assisted Living Facility	☐ 50% of NH ☐ 70% of NH ☐ 100% of NH
	Home Health Care	Basic and Professional Home Health Care ☐ 50% Basic / 100% Professional ☐ 100% Basic / 200% Professional ☐ 150% Basic / 300% Professional
Plan Length Options		☐ 2 Year ☐ 3 Year ☐ 4 Year ☐ 5 Year ☐ 6 Year ☐ 8 Year ☐ Lifetime
Elimination Period Options		☐ 30 Day ☐ 60 Day ☐ 90 Day
		☐ Waiver of Elimination Period for Home Health Care
Inflation Protection Options		☐ 5% Simple ☐ 2.5% Compound ☐ 3% Compound ☐ 3.5% Compound ☐ 4% Compound ☐ 4.5% Compound ☐ 5% Compound Lifetime ☐ 5% Compound – 10 Year ☐ 5% Compound – 20 Year
Spousal Benefits		☐ Spouse Shared Benefit
Other Optional Benefits		☐ Monthly Basic and Professional Home Health Care ☐ Nonforfeiture / Shortened Benefit Period

F Assured Solutions *Plus* Benefit Selection

Assured Solutions *Plus*

☐ **Tax Qualified** ☐ **Non-Tax Qualified**

Maximum Daily Benefit	Nursing Home (NH)	$ _____ per day ($50-$500, in $10 increments)
	Assisted Living Facility	☐ 50% of NH ☐ 60% of NH ☐ 70% of NH ☐ 80% of NH ☐ 100% of NH
	Home Health Care	Basic and Professional Home Health Care ☐ 50% Basic / 100% Professional ☐ 100% Basic / 200% Professional ☐ 150% Basic / 300% Professional
Plan Length Options		☐ 2 Year ☐ 4 Year ☐ 6 Year ☐ Lifetime ☐ 3 Year ☐ 5 Year ☐ 8 Year
Elimination Period Options		☐ 0 Day ☐ 60 Day ☐ 180 Day ☐ 30 Day ☐ 90 Day ☐ 365 Day ☐ Waiver of Elimination Period for Home Health Care
Inflation Protection Options		☐ 5% Simple ☐ 2.5% Compound ☐ 3% Compound ☐ 3.5% Compound ☐ 4% Compound ☐ 4.5% Compound ☐ 5% Compound Lifetime ☐ 5% Compound – 10 Year ☐ 5% Compound – 20 Year
Payment Options		☐ Lifetime ☐ 10-Pay ☐ 20-Pay ☐ To-Age-65 (Note: Spouse WOP and Survivorship Benefit are not available with 10-Pay, 20-Pay or To-Age 65.)
Spousal Benefits		☐ Spouse Waiver of Premium (WOP) and Survivorship Benefit ☐ Spouse Shared Benefit ☐ Spouse Security Benefit* (Note: Spouse Shared Benefit is not available with any ROP at Death Benefit.)
Other Optional Benefits		☐ Monthly Basic and Professional Home Health Care ☐ Restoration of Benefits ☐ Return of Premium (ROP) at Death ☐ Return of Premium (ROP) at Death Less Claims ☐ Nonforfeiture / Shortened Benefit Period Additional Years of Rate Guarantee (5 years built in) ☐ 1 yr ☐ 2 yrs ☐ 3 yrs ☐ 4 yrs ☐ 5 yrs

*Please Include your Spouse's Name _____ and Social Security #:_____

G Plan Information

Mode of Payment

☐ Monthly EFT (.09) ☐ Quarterly (.26) Annual Premium $ _____

☐ Semi-Annual (.51) ☐ Annual (1.00) Modal Premium $ _____

or **Payment with Application** $ _____

☐ Group List Bill (Do not submit premium at this time; billing will occur after issue.)

☐ Payroll Location _____

Specify Effective date:

☐ Date of Application

☐ Date Policy is Issued ("My Chosen Effective Date")

☐ For Replacements Only, Requested Effective Date of Coverage _____(up to 60 days from application date – "My Chosen Effective Date")

Payer if other than insured or alternate mailing address for premium notices _____

Name

_____

Number, Street, Apartment Number

_____

City State ZIP Code

H Notice Before Lapse or Termination

Please check the applicable box and complete the requested information.

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

Third Party _____

Please print the full name of other person to receive notice of lapse or termination

Third Party's Mailing Address _____

Street No. City State ZIP Code

Waiver: 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.

☐ I elect NOT to designate any person to receive such notice. If checked, signature below must be complete.

X _____ Date _____

Signature of Proposed Insured Mo. Day Yr.

I Agreements

I, the undersigned, certify that I have read the completed application and understand and agree that:

1 All answers in this application are true and complete and will be relied on by United of Omaha Life Insurance Company to determine insurability. Any incorrect or misleading answers may void this application and any issued policy, effective the issue date.

2 In order for United of Omaha Life Insurance Company to issue a policy as a result of this application: **(1)** all required examinations and tests (medical, paramedical, laboratory) must be completed, **(2)** United of Omaha Life Insurance Company must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician's Statement) that it requires and, **(3)** this application must be approved for issue by United of Omaha Life Insurance Company's Underwriting Department. **If (1), (2) or (3) is not met, no policy will be issued and no coverage will be in effect except coverage under a Temporary Insurance Agreement and Receipt ("TIA"), if a TIA was delivered to me the date the application was completed. Any coverage under a TIA is subject to the requirements set forth in the TIA, and benefits under a TIA are limited to a period of 1 year after the date a claim under the TIA begins.**

3 If the initial premium is paid on the date the application is completed and the insurance policy applied for is issued, the policy will be effective as of the date of the application. However, I may elect to delay the effective date until a later date selected by me on the application ("My Chosen Effective Date"), and if I do so, I understand no coverage will be effective until My Chosen Effective Date. **Also, if there is a change in my health or habits between the date the application is completed and My Chosen Effective Date, I understand that no coverage will be provided under the policy, and the only coverage that will be provided is coverage under a TIA, if a TIA was delivered to me on the date the application was completed.**

4 If **(1)** the initial premium is not collected at the time this application is completed, or **(2)** United of Omaha Life Insurance Company offers a different policy than the policy applied for, then coverage under the policy will become effective only if, when the policy is delivered to me: **(a)** the initial premium is paid, and **(b)** all delivery requirements (including the execution and delivery of a delivery receipt by the insured and policyowner, if required) are completed. The initial premium will provide coverage from the date coverage is effective until the date the next premium is due under the policy.

5 In no event will benefits be paid for the same loss under both a Temporary Insurance Agreement and Receipt and any policy issued from this application.

6 I received the Notice of Information Practices Notice and the Investigative Consumer Reports Notice before completing this application.

7 If the applicant is other than the Proposed Insured, the applicant will own the policy.

8 No producer can waive or change any Receipt or policy provision or agree to issue a policy.

PLEASE READ AND INITIAL IF 5% <u>COMPOUND LIFETIME</u> INFLATION PROTECTION IS <u>NOT</u> 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 (Lifetime) Protection option**.** Specifically, I have reviewed options for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation (Lifetime) Protection option. If I purchase another inflation protection option that is offered, that option will be included as part of my policy, as shown on the Policy Schedule/Schedule of Benefits.

_____**Initials of Proposed Insured – 5% <u>Compound Lifetime</u> Inflation Protection Rejection**

PLEASE READ AND INITIAL IF NONFORFEITURE BENEFIT IS <u>NOT</u> 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 has been made available and I reject the "Nonforfeiture Benefit **-** Shortened Benefit" option that is available.

_____**Initials of Proposed Insured – Nonforfeiture Benefit – Shortened Benefit Rejection**

I acknowledge receipt of, if applicable:

☐ **Outline of Coverage**
☐ **Shopper's Guide to Long-Term Care Insurance**
☐ **Potential Rate Increase Disclosure Form**
☐ **Guide to Health Insurance for People with Medicare**

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

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

I have read and understand the Agreement Section, including the Fraud Warning Statement, and the Temporary Insurance Agreement and Receipt, if one was delivered, and I approve all my answers as recorded in this application.

Signed at _____ **X** _____ Date _____
City State Signature of Proposed Insured Mo. Day Yr.

I/We, the Producer(s) certify that each question was asked exactly as written and I/We have recorded the answers provided by the Proposed Insured completely and accurately. ☐ Yes ☐ No (If "No," please explain) _____

X _____ **X** _____
Signature of Licensed Producer Signature of Licensed Producer

Appendix 1 Authorization to Disclose Personal Information To United of Omaha Life Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization To Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to United of Omaha Life Insurance Company.

Purposes

The Personal Information will be used to determine my or my children's eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure To Sign

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

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Names and Signatures

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

Printed Name of Proposed Insured	Spouse's Printed Name (If Proposed Insured)	If children are to be insured, their printed names
X _____	_____	_____
Signature of Proposed Insured	Signature of Spouse (If Proposed Insured)	Signature of Parent or Guardian (If Proposed Insured is a Minor)
_____	_____	_____
Date	Date	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Appendix 2 Authorization to Withdraw Funds by United of Omaha Life Insurance Company

Form _____ Proposed Insured _____

Specify the date premiums will be withdrawn (1st through the 28th of the month):_____ Withdrawals made on a monthly basis.

Routing Number _____ Account Number _____

Attach your voided check from the account where premiums will be withdrawn.

Authorization to Withdraw Funds by United of Omaha Life Insurance Company

As a convenience to me, I authorize United of Omaha Life Insurance Company to withdraw funds from my account.

I also authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to United of Omaha Life Insurance Company. 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.

Date _____

X _____
Authorized Signature as Shown on Account

Appendix 3 Association/Employer Sales

Association Information:

Full Name of Organization _____

Association Service Group Number _____

Relationship to above:

☐ Member

☐ Spouse of Member
Name of Member _____

☐ Other Qualifying Family Member
(Adult children age 18 and older, Parents and/or Parents-in-Law, Other _____)

Name of Association Member _____

Employer Information (if employer sponsored):

Company Name _____

Name of Owner/President _____

Company Address _____

City _____ State _____ ZIP Code _____

Service Group Number _____

☐ Full Time Employee
☐ Part Time Employee
☐ Retired

☐ Spouse of Employee
Name of Employee _____
☐ Other Qualifying Family Member
Name of Employee _____

Appendix 4 Producer Statement

		Yes	No
1	I/We certify that the Notice of Information Practices and Investigative Consumer Reports Notice was given to the Proposed Insured.....	☐	☐
2	I/We certify that each question was asked exactly as written and recorded the answers completely and accurately in the presence of the Proposed Insured.	☐	☐

(If "No," explain) _____

3 To the best of my knowledge, replacement of other insurance ☐ is ☐ is not 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.

Date _____ Signature of Producer **X** _____

Date _____ Signature of Producer **X** _____

Producer Information

Producer's Name _____ Social Security No. _____

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____ Producer # _____

Producer's Name _____ Social Security No. _____

Comm. % Share _____ Producer's Phone No. (_____) _____

Producer's E-mail Address _____ Producer # _____

Who should we contact with questions regarding this pending application:

Name _____

Phone Number (_____)_____

E-mail _____

Appendix 5 Temporary Insurance Agreement and Receipt ("Agreement")

All Checks for Premiums Must be Made Payable to United of Omaha Life Insurance Company
Do Not Make Checks Payable to the Producer or Leave the Payee Blank.

United of Omaha Life Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St, Paul, MN 55164-0901

Policy form (rider) applied for LTC06UI

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, United of Omaha Life Insurance Company agrees to provide limited temporary long-term care insurance for the Proposed Insured, subject to the following conditions and limitations:

1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Proposed Insured lives, on the latest of these dates:
- **(a)** The date the above sum is received; or
- **(b)** The date the application is signed by the Producer(s) and Proposed Insured; or
- **(c)** The date this Agreement is signed by the Producer(s) and Proposed Insured.

2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Proposed Insured lives, on the earliest of the following dates:
- **(a)** 90 days from the date of this Agreement; or
- **(b)** the date that insurance takes effect under the policy applied for; or
- **(c)** the date a policy, other than as applied for, is offered by a Producer to the Proposed Insured; or
- **(d)** the date United of Omaha Life Insurance Company mails the premium refund and letter informing the Proposed Insured that the policy applied for will not be issued; or
- **(e)** the date United of Omaha Life Insurance Company mails notice of termination of this Agreement to the Proposed Insured.

3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series; **but in no event shall benefits be payable to a Proposed Insured under this Agreement for more than one year after the date a claim begins under this Agreement.**

4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5 **In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.**

6 If any of the answers to the questions on the application given by the Proposed Insured are incorrect or misleading, then this Agreement is void as to that Proposed Insured and never went into effect.

This Agreement does not limit United of Omaha Life Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of a Proposed Insured is rejected by United of Omaha Life Insurance Company, the amount paid with the application for that Proposed Insured will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____
Month Year City State Zip Code

X _____ _____
Proposed Insured's Signature Please print name

X _____
Producer's Signature

X _____
Producer's Signature

Company Copy

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Appendix 5 Temporary Insurance Agreement and Receipt ("Agreement")

All Checks for Premiums Must be Made Payable to United of Omaha Life Insurance Company
Do Not Make Checks Payable to the Producer or Leave the Payee Blank.

United of Omaha Life Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St, Paul, MN 55164-0901

Policy form (rider) applied for LTC06UI

In consideration of the application and payment of $ _____ by the Proposed Insured, receipt of which is hereby acknowledged, United of Omaha Life Insurance Company agrees to provide limited temporary long-term care insurance for the Proposed Insured, subject to the following conditions and limitations:

1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Proposed Insured lives, on the latest of these dates:
- **(a)** The date the above sum is received; or
- **(b)** The date the application is signed by the Producer(s) and Proposed Insured; or
- **(c)** The date this Agreement is signed by the Producer(s) and Proposed Insured.

2 The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Proposed Insured lives, on the earliest of the following dates:
- **(f)** 90 days from the date of this Agreement; or
- **(g)** the date that insurance takes effect under the policy applied for; or
- **(h)** the date a policy, other than as applied for, is offered by a Producer to the Proposed Insured; or
- **(i)** the date United of Omaha Life Insurance Company mails the premium refund and letter informing the Proposed Insured that the policy applied for will not be issued; or
- **(j)** the date United of Omaha Life Insurance Company mails notice of termination of this Agreement to the Proposed Insured.

3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series; **but in no event shall benefits be payable to a Proposed Insured under this Agreement for more than one year after the date a claim begins under this Agreement.**

4 **No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.**

5 **In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.**

6 If any of the answers to the questions on the application given by the Proposed Insured are incorrect or misleading, then this Agreement is void as to that Proposed Insured and never went into effect.

This Agreement does not limit United of Omaha Life Insurance Company in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of a Proposed Insured is rejected by United of Omaha Life Insurance Company, the amount paid with the application for that Proposed Insured will be refunded to the Proposed Insured regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____, _____ at _____
Month Year City State Zip Code

X _____ _____
Proposed Insured's Signature Please print name

X _____
Producer's Signature

X _____
Producer's Signature

Proposed Insured's Copy

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Appendix 6 United of Omaha Life Insurance Company Notice of Information Practices

In the course of properly underwriting and administering Your insurance coverage, we will rely heavily on information provided by You. We may also collect information from others, such as medical professionals who have treated You, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release Your personal or privileged information in our/their files, to third parties without Your authorization. You have the right to be told about and to see a copy of items of personal information about You which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information You believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which You apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge You to review Your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, LONG-TERM CARE SERVICE OFFICE, P.O. BOX 64901, ST. PAUL, MN 55164-0901.

Appendix 7 Investigative Consumer Reports Notice

United of Omaha Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about You is obtained through personal interviews with Your neighbors, friends, associates, acquaintances or others who may have knowledge relating to Your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform You whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide You the name, address and telephone number of the consumer reporting agency so that You may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

Detach this page and leave with the Proposed Insured

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

United of Omaha Life 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 United of Omaha Life 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 _____
Producer's Signature

_____
Print Name and Address of Producer

The above "Notice to Applicant" was delivered to me on:

_____
Date

X _____
Applicant's Signature

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

United of Omaha Life 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 United of Omaha Life 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 _____
Producer's Signature

_____
Print Name and Address of Producer

The above "Notice to Applicant" was delivered to me on:

_____
Date

X _____
Applicant's Signature

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Long-Term Care Insurance Personal Worksheet

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

Mutual of Omaha
United of Omaha Life Insurance Company

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) LTC06UI

The premium for the coverage you are considering will be $_____ per month, or $_____ per year.

Type of Policy: Guaranteed Renewable

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.

Rate Increase History

The company has sold long-term care insurance since 2006 and has sold this policy form since 2006. The company has never raised its premium rates for any long-term policy form it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium? (Check one)
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (Check one)
☐ Under $10,000 ☐ $10-15,999 ☐ $16-29,999 ☐ $30-50,000 ☐ Over $50,000

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.

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?
☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of nursing home care in 2005 was $66,153, but this figure varies across the country. In ten years the national average annual cost would be about $107,756 if costs increase 5% annually.

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

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

Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one)
☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (Check one)
☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

Check one

☐ The answers to the questions above describe my financial situation.	☐ I choose not to complete this information.

☐ 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.** (This box must be checked).

Signed: **X** _____ _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed: **X** _____ _____
(Producer) (Date)

Producer's Printed Name: _____

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.

Signed: **X** _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

I hereby confirm that I elect not to complete the Long-Term Care Insurance Personal Worksheet. However, I request that you continue to process my application for Long-Term Care Insurance coverage.

Signed: **X** _____ _____
(Applicant) (Date)

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

Mutual of Omaha

United of Omaha
Life Insurance Company

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 $_____

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 total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining 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	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

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

Mutual of Omaha

United of Omaha
Life Insurance Company

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' "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. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

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Conversion Offer

I understand that I have been given the opportunity to exchange my United of Omaha Life Insurance non-tax qualified Long-Term Care policy at any time during the life of the policy (if issued) without evidence of insurability. If my non-tax qualified plan includes the Informal Caregiver Benefit, it will be terminated once the policy is exchanged.

I also understand that **if** my current non-tax qualified Long-Term Care policy does not contain inflation and/or nonforfeiture benefits:

1. then the tax qualified plan for which I'm requesting conversion will not have such benefits; or
2. if I want inflation and/or nonforfeiture benefits under the tax qualified plan: (a) I need to contact my United of Omaha Life Insurance Company representative in order to apply for coverage; (b) eligibility will be based upon my current health; and (c) premiums will be based upon my current age.

Applicant Signature: **X** _____ Date: _____

Producer Signature: **X**_____ Date: _____

Producer Copy

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Conversion Offer

I understand that I have been given the opportunity to exchange my United of Omaha Life Insurance non-tax qualified Long-Term Care policy at any time during the life of the policy (if issued) without evidence of insurability. If my non-tax qualified plan includes the Informal Caregiver Benefit, it will be terminated once the policy is exchanged.

I also understand that **if** my current non-tax qualified Long-Term Care policy does not contain inflation and/or nonforfeiture benefits:

1. then the tax qualified plan for which I'm requesting conversion will not have such benefits; or
2. if I want inflation and/or nonforfeiture benefits under the tax qualified plan: (a) I need to contact my United of Omaha Life Insurance Company representative in order to apply for coverage; (b) eligibility will be based upon my current health; and (c) premiums will be based upon my current age.

Applicant Signature: **X** _____ Date: _____

Producer Signature: **X**_____ Date: _____

Customer Copy

G94

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Senior Health Insurance Counseling

Please be advised that senior health insurance counseling is available at:

Colorado Division of Insurance
1-303-894-7499
or
Centura Health Insurance
Counseling for Seniors
1-800-544-9181