

Application for Group Insurance

Mutual of Omaha Insurance Company
Home Office: Omaha, Nebraska



(Please complete in black ink.)

Section 1 - Must Be Completed By the Employer

Group No. _____ Date employee's full-time employment began _____
 Employer's name _____
 Employer's address _____
 Employees job description _____ Annual Salary _____
 Signed for employer by _____ Employer phone number: _____

Section 2 - To Be Completed By You

Name _____ Soc. Sec. No. _____ - _____ - _____
 (Last) (First) (Middle)
 Address _____ Applicant's Phone # _____
 (Street) (City) (State) (ZIP Code)
 Date of Birth _____ Place of birth _____ Height _____ Weight _____ Sex _____
 (Mo.) (Day) (Yr.) (Include State if Born in U.S.)

- During the past 10 years, have you ever received care for or had any disease or disorder associated with the following:
 (Check all that apply.)

<input type="checkbox"/> Urinary Tract or Kidney	<input type="checkbox"/> Cancer or Tumor
<input type="checkbox"/> Coronary Arteries or Heart	<input type="checkbox"/> Alcohol or Drug Use
<input type="checkbox"/> Liver or Hepatitis	<input type="checkbox"/> Stroke or Cerebral Vascular condition
<input type="checkbox"/> Diabetes or Glandular condition	<input type="checkbox"/> Psychological, Emotional or Nervous condition
<input type="checkbox"/> Upper or Lower Digestive Tract	<input type="checkbox"/> Spine, Neck or Back
<input type="checkbox"/> High Blood Pressure, Arteries or Veins	<input type="checkbox"/> Arthritis or Joints (including replacements)
<input type="checkbox"/> Anemia or Blood	<input type="checkbox"/> Lung or Breathing Problem
<input type="checkbox"/> Breast or Male/Female Reproductive Organs (including implants, infertility, irregular menstruation, complication of pregnancy)	<input type="checkbox"/> Neurological condition (including Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)
<input type="checkbox"/> Skin or Connective Tissue	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Fibromyalgia or Myalgia
	<input type="checkbox"/> None of These
- 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? Yes No
- During the past 10 years, other than shown in questions 1 and 2, have you been diagnosed or treated by a health care provider; had or been advised to seek treatment for any illness, injury or disorder; had surgery; been hospitalized; had a medical examination; diagnostic or medical evaluation or received medical care? Yes No
- Within the past six months, have you taken any prescription medication? Yes No

If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name (Copy Off of Pharmacy Label)	Dosage/Frequency	Date	Prescribing Physician	Reason

- During the past 10 years, have you used unlawful drugs in any form or used prescription drugs other than as prescribed (including sedatives, tranquilizers, cocaine, hallucinogens or narcotics) in any form? Yes No
- Are you pregnant? Yes No If "Yes," give anticipated delivery date _____.
- Have you been absent from work more than five consecutive working days because of illness or injury during the past five years? Yes No
- Complete this section to expand on questions 1, 2, 3 and 7. (Attach a separate, signed sheet, if necessary)

Condition, Injury, or Findings of Examination (If Operation Performed, State Type)	Month and Year	Duration	Degree of Recovery	Name, Address and ZIP Code of Hospital and Attending Physician

PLEASE NOTE: If additional medical information is required to complete our processing, a delay in response may make it necessary for us to request a current application. This application is valid for 60 days from your signature date.

STATEMENT OF APPLICATION AND AUTHORIZATION

I apply to Mutual of Omaha Insurance Company for group insurance coverage for myself. I understand that any insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha approves such amounts. I have given the above answers to obtain this insurance. Information in this application, a copy of which shall be attached to and made a part of my certificate when issued, is given to obtain the program requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I understand that insurance does not begin until my insurance certificate is issued and the first premium paid. I permit my employer to deduct the monthly premium contribution from my earnings.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Authorization to Receive and Disclose Information

Meanings of Terms

“MIB Group, Inc. (MIB)” means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me.

“Specified Companies” means:

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

To the MIB:

I authorize you to disclose Personal Information about me, (the undersigned), to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

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

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

Attn: Group Specialty Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

Signature of Employee

Date