

# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

P.O. Box 3608 Omaha, Nebraska 68103-3608



## Application Submission Checklist To United World For Medicare Supplement Coverage – PENNSYLVANIA

### THIS APPLICATION MUST BE USED TO WRITE UNITED WORLD MEDICARE SUPPLEMENT PRODUCTS

- Application**
  1. Complete “Plan Information” Box.
  2. Refer to the Outline of Coverage for policy forms.
  3. Answer all questions in full.
  4. Sign and Date in all places indicated.
  5. Be sure to leave all applicable forms with the proposed insured.
  6. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
  - The full modal premium is collected at the time of application.
  - Calculate the premium based on age at time of application.
  - Tobacco rates do not apply during Open Enrollment or Guarantee Issue situations.
- Provide Client with Buyer’s Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- If applicable, complete the Authorization for Electronic Funds Transfer form (ACH/BSP form M26238\_0409) and return with the completed application.**
- Provide Client with Conditional Receipt signed by Agent (if applicable), and provide Client with Notice of Information Practices**
- Complete, sign and provide Client with copy of the Authorization To Disclose Personal Information (HIPAA form W24903\_0709). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**
- Complete Replacement Notice (W24680\_0605) and leave a copy with the applicant (if applicable)**
- Provide Client with PA-Guaranteed Issue and Open Enrollment Notice (W26254)**

**Please provide additional information and comments  
in the space provided on the application.**

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**Note:** An interviewer may call to verify/confirm the information provided on the application.

**BROKERAGE ONLY – Please list your “commission code” in the box on the first page of the application. This will help avoid delay in commission payment.**

**There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.**

## **1. Application – Agent Completes in Full: (please print)**

### **“Plan Information” Box**

- Policy Form
  - Requested Effective Date
  - Premium Collected (Amount)
  - Initial Mode\* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
  - Renewal Premium (Amount)
  - Renewal Mode\* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
- \*Direct Monthly billing not available

### **Part I “General Information”–**

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant’s current age at time of application.
- The applicant’s Social Security number as indicated from applicant’s Social Security Card.
- For applicants already covered by Medicare, include applicant’s Medicare number on the application as indicated from the applicant’s Medicare Health Insurance Card. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent **must** provide this number by calling 1-877-617-5587 once it is received.

### **Part II “Existing Coverage Information”–**

- Please complete all questions in full.
- If the applicant is not covered by Medicare, indicate “Eligibility Date” and “Date of Enrollment”.
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
  - Name of Company
  - Issue Date
  - Policy/Certificate Number
  - Termination/Disenrollment Date
  - Plan
  - Kind of Policy

**Note:** An interviewer may call to verify/confirm the information provided on the application.

## **2. Administrative Forms**

### **Producer/Agent Information**

- Be sure to include your Social Security number and commission code.  
**NOTE: This information is necessary for the underwriting process and commission payment.**
- Include your telephone number, e-mail address and FAX number for contact purposes.

### **Authorization for Electronic Funds Transfer by United World Life Insurance Company (ACH/BSP) –**

**If applicant chooses to pay premium by ACH/BSP, complete this form accurately and in its entirety and return with the application.**

- **Option A** - Pay all premiums (1st & monthly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium **MUST** be submitted with the application.
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment.

### **Conditional Receipt and Notice of Information Practices**

- Complete and sign the receipt (if applicable), detach entire page and leave with applicant.

### **Authorization To Disclose Personal Information (HIPAA)**

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.

### **Replacement Notice – complete if applicable**

- Complete form including signature and date.
- Leave a copy with applicant (if applicable).

### **State – Specific Forms – complete if applicable**

- Be sure to include all state appropriate forms.



(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.  
 START \_\_\_\_ / \_\_\_\_ / \_\_\_\_ END \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(c) Reason for termination/disenrollment? \_\_\_\_\_

(d) Date of termination/disenrollment. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

7. (a) Do you have another Medicare supplement insurance policy in force?..... Yes  No

(b) If so, with what company, and what plan do you have?

| Name of Company | Policy/Certificate Number | Plan | Issue Date |
|-----------------|---------------------------|------|------------|
|                 |                           |      |            |

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ..... Yes  No

(d) If "Yes," indicate termination date. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Have you received a copy of the Replacement Notice? .....** Yes  No   
 Mo Day Yr

8. Are you covered for medical assistance through the state Medicaid program? NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. .... Yes  No

If yes, (a) Will Medicaid pay your premiums for this Medicare supplement policy? ..... Yes  No

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?..... Yes  No

9. Producers shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

| Name of Company | Policy/Certificate Number | Description of Benefits | Effective Date of Coverage |
|-----------------|---------------------------|-------------------------|----------------------------|
|                 |                           |                         |                            |

(b) List policies sold in the past five (5) years which are no longer in force.

| Name of Company | Policy/Certificate Number | Description of Benefits | Effective Date of Coverage |
|-----------------|---------------------------|-------------------------|----------------------------|
|                 |                           |                         |                            |

**PART III. HEALTH /MEDICAL QUESTIONS (COMPLETE IN FULL)**

1. If the answer is "Yes" to any of the following health questions (a)-(n), you are not eligible for coverage. (If you are applying for coverage during open enrollment or during a guaranteed issue period, do not answer questions 1 & 2 in section III.)

- |   |                          | Yes                      | No                       |
|---|--------------------------|--------------------------|--------------------------|
| (a) Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Have you been diagnosed by a member of the medical profession with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Have you been diagnosed by a member of the medical profession with Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Have you been diagnosed by a member of the medical profession with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Have you been diagnosed with or medically treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Have you been diagnosed by a member of the medical profession with diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Do you have diabetes that has ever required more than 50 units of insulin daily? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse; cirrhosis; mental or nervous disorder requiring psychiatric care; or have you had any amputation caused by disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure); peripheral vascular disease; congestive heart failure or enlarged heart; stroke; transient ischemic attacks (TIA), or heart rhythm disorders? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Within the past two years have you been treated for or medically diagnosed with degenerative bone disease, crippling/disabling or rheumatoid arthritis, or have you been advised by a member of the medical profession to have a joint replacement? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ...  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Have you been hospital confined three or more times in the last two years? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Have you had an organ transplant or been advised by a physician to have an organ transplant? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (o) Have you used tobacco in any form in the past 12 months? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? ..... Yes  No   
 If “Yes,” please list the drug and the condition. (Use page 4 of application, if more space is necessary.)

| Medication Name (copy off pharmacy label) | Date <b>Originally</b> Prescribed | Frequency and Dosage | Diagnosis/Condition |
|---|-----------------------------------|----------------------|---------------------|
|   |                                   |                      |                     |
|   |                                   |                      |                     |
|   |                                   |                      |                     |
|   |                                   |                      |                     |

NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payments.

**PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- (a) You do not need more than one Medicare supplement policy.
- (b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.
- (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (d) If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (e) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).
- (g) Your signature is an acknowledgement and agreement to the plan information and premium option selected on page one on this application.

I represent that my answers and statements are true and complete and agree that no insurance will be effective unless a policy is issued. 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.

Dated at \_\_\_\_\_, on \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 (City) (State) (Month) (Day) (Year) (Signature of Applicant)

**Premium Must Accompany Application**

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

\_\_\_\_\_  
 Signature of Licensed Producer  
 PRODUCER STAMP

\_\_\_\_\_  
 Signature of Licensed Producer  
 PRODUCER STAMP

\_\_\_\_\_  
 Signature of Licensed Producer  
 PRODUCER STAMP



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## Policy Delivery

Mail policy to:

Applicant           Producer

## Producer(s) Information

Producer Name \_\_\_\_\_ Social Security No \_\_\_\_\_  
Comm. % Share \_\_\_\_\_ Producer Phone No (\_\_\_\_) \_\_\_\_\_ Commission Code \_\_\_\_\_  
Producer E-mail Address \_\_\_\_\_ @ \_\_\_\_\_  
Producer FAX Number \_\_\_\_\_

Producer Name \_\_\_\_\_ Social Security No \_\_\_\_\_  
Comm. % Share \_\_\_\_\_ Producer Phone No (\_\_\_\_) \_\_\_\_\_ Commission Code \_\_\_\_\_  
Producer E-mail Address \_\_\_\_\_ @ \_\_\_\_\_  
Producer FAX Number \_\_\_\_\_

(Note: Producers must be under the same commission code to share or split commissions.)

## Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

### Initial Payment

| Is the applicant:  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| (a) unemployed?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) employed, but not working for the business that is paying the premium? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) the business owner or spouse of the business owner? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

### Renewal Payment

| Is the applicant:  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| (a) unemployed?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) employed, but not working for the business that is paying the premium? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) the business owner or spouse of the business owner? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

## INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (ACH/BSP) FORM

|   |                            |   |  |
|---|----------------------------|---|--|
| Account Holder Name                               | Check Number               |   |  |
| John Doe<br>Street Address<br>Town, City Zip code | Check #1234<br>Date: _____ |   |  |
| Pay to: _____<br>_____ Dollars                    |                            |   |  |
| Bank Name<br>& Address                            |                            |   |  |
| Memo _____  | Signed By: _____           |   |  |
| :123456789:  12345678    1234                     |                            |   |  |
| Bank Routing/<br>Transfer Number                  | Bank Account<br>Number     | Check Number<br>(if shown at bottom, may be<br>before or after the account #) | Do <b>NOT</b> include the check number as part<br>of either the Routing or Account Number. |

The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

**Option A: Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).**

**Automated Clearing House (ACH)** is used for initial payment and **Bank Service Plan (BSP)** is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

**Option B: Pay 1st month by paper check and monthly renewals by BSP**

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

**Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)**

When choosing to pay the initial premium by ACH and renewal premiums by direct billing (annually, semiannually, or quarterly), the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

**When choosing to pay initial premium by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.**

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the ACH/BSP form accurately and in its entirety, making sure that all required information is correct and complete on your ACH/BSP form prior to submission. In addition, please make sure that the premium amount is filled in on the ACH/BSP form, so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

**Authorization for Electronic Funds Transfer (ACH/BSP)**

**This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.**

- Medicare Supplement Premium Payment Options:**
- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| (ACH is used for initial payment and BSP is used for renewal payments.)  |                          |                          |
| B. Pay initial premium by signed paper check and pay monthly renewals by BSP .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Pay initial premium by ACH and pay renewals by direct bill ( <b>monthly direct billing is not offered</b> ) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| • If choosing Options A or C, list amount of initial premium withdrawal, if applicable ..... \$ _____                  |                          |                          |
| • If choosing Options A or B, select a withdrawal date for monthly BSP renewal payments (circle one) ..... 1st or 15th |                          |                          |
| • Is a business account being used to pay premiums?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| • If yes, is the applicant:  |                          |                          |
| (a) Unemployed.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Employed, but not working for the business that is paying the premium .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) The business owner or spouse of the business owner .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If (a), (b), or (c) are "Yes," premiums CAN be paid with a business account.</b>                                    |                          |                          |

**Account Type (check one):**                       Checking             Savings

**Complete information below. To avoid potential delays in processing, submit a copy of a voided check.**

\_\_\_\_\_  
Name of Financial Institution

\_\_\_\_\_  
Routing Number (first 9 digits on lower left side of check)

\_\_\_\_\_  
Account Number (Do NOT use Debit or Credit Card account numbers)

\_\_\_\_\_  
Name as Shown on Account

**IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.**

I authorize Mutual of Omaha and/or United World Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha and/or United World Life Insurance Company 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 and/or United World Life Insurance Company. Your rights with each charge will be the same as if personally paid by me. The 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.

\_\_\_\_\_  
**Authorized Signature as Shown on Account**

\_\_\_\_\_  
**Date**

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## Conditional Receipt

### Check or Money Order Application

All premiums must be made payable to the United World Life Insurance Company.

**Do not make check or money order payable to the agent or leave the payee blank.**

Received of \_\_\_\_\_  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ an application  
for a Form \_\_\_\_\_ Policy and Riders \_\_\_\_\_  
and Check or Money Order for \_\_\_\_\_ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent \_\_\_\_\_

**NOTICE TO APPLICANT:** Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

**If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.**

**Complete Receipt in full and leave with applicant at time of application.**

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## United World 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. Upon request, 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 WORLD LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

**Give this notice to the applicant.**

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## Authorization To Disclose Personal Information To United World 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. 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, 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 to United World Life Insurance Company.

### Purposes

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

### Potential for Redislosure

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 World 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 World Life Insurance Company has taken action in reliance on the authorization or the law allows United World 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): \_\_\_\_\_

| Applicant                          | Applicant B                        |
|------------------------------------|------------------------------------|
| Printed Name of Proposed Applicant | Printed Name of Proposed Applicant |
| Signature of Proposed Applicant    | Signature of Proposed Applicant    |
| Date                               | Date                               |

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## Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by United World Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

### Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and 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, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy or certificate until you have received your new policy and are sure that you want to keep it.

**X** \_\_\_\_\_  
**Signature of Agent, Broker or Other Representative\***

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

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

1 - Home Office Copy

2 - Applicant Copy

# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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## Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by United World Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

### Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
  - No change in benefits, but lower premiums
  - Fewer benefits and lower premiums
  - My plan has outpatient prescription drug coverage and I am enrolling in Part D
  - Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment
  - Other (please specify) \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and 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, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy or certificate until you have received your new policy and are sure that you want to keep it.

**X** \_\_\_\_\_  
**Signature of Agent, Broker or Other Representative\***

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

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

1 - Home Office Copy

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# UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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## Guaranteed Issue and Open Enrollment Notice

### The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

- (a) Enrolled under an employee welfare benefit plan and the plan terminates or ceases to provide benefits or the individual is no longer eligible for the plan;
- (b) Enrolled in a Medicare Advantage plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost) (42 U.S.C.A. 1935mm), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851 (e) of the Social Security Act), or
- (f) Upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.
- (g) Enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the Insured Person terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy that is classified as a Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

If any of the definitions apply to you, please complete the Application for Medicare supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

### Open Enrollment

An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this Commonwealth, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this section without regard to age. In the case of group policies, an issuer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

**Give This Copy To The Applicant**