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

Please mail the completed application to:

Express-quote Insurance
Carl E. Souders
1825 White Oak Rd.
Blairsville,GA 30512

Agent Completes in Full: (please print)

"Plan Information" Box

- Policy Form
- Riders (MN & WI only)
- Requested Effective Date
- Premium Collected (Amount)
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
  *Direct Monthly billing not available

Part I "General Information"–

- Residence address and ZIP code are indicated. Alternate address for billing is indicated (when applicable).
- The applicant's age is the age at time of application.
- Social Security number is correctly indicated on application.

Part II "Existing Coverage Information"–

- Medicare card number (Health Insurance Claim Number) is correctly indicated for applicants already covered by Medicare. 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.
- 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
  - – Policy/Certificate Number
  - – Plan
  - – Issue Date
  - – Termination/Disenrollment Date
  - – Kind of Policy

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

2. Administrative Forms

Authorization to Withdraw Funds by United World Insurance Company (BSP/ACH) – complete if applicable

- Payments will be taken monthly, on the 1st or the 15th of the month. You do not need to provide a voided check, unless the premium is to be paid from a separate account. Checking account information will be taken from the accompanying premium check.

Authorization To Disclose Personal Information

- When Replacing a Product With a United World or Mutual of Omaha Product,
  Please Complete the Authorization To Disclose Personal Information

Replacement Notice – complete if applicable

- Complete and leave a copy with applicant (if applicable).

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:
PLAN INFORMATION (to be completed by **Producer**)		
Policy Form	Requested Effective Date:	
Spouse applying for coverage (different application)?	Yes ☐ No ☐	
Premium Collected $	Initial Mode **A, S, Q or B**	
Renewal $	Renewal Mode **A, S, Q or B** (monthly not allowed)	

Application To United World Life Insurance Company For Medicare Supplement Coverage

PART I. GENERAL INFORMATION

1. Print Name_______________ Home Phone No.(______)__________
   (Title) (First) (Middle) (Last) (Area Code)
2. Residence Address_______________
   (No. and Street and Apt. No.) (City) (State) (ZIP Code)
3. Mailing Address_______________
   (No. and Street and Apt. No.) (City) (State) (ZIP Code)
4. Birth Date____/____/____ Age ________ Sex: M ☐ F ☐ Height:______Ft. ______ In. Weight ________Lbs.
   Mo. Day Yr. ***(current age)***
5. Social Security No.______________ E-mail Address: ______________
6. Have you received a copy of the ***Guide to Health Insurance for People with Medicare*** and the Outline of Coverage?... Yes ☐ No ☐
7. Have you used tobacco in any form in the past 12 months?........ Yes ☐ No ☐

PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

To the best of your knowledge:

1. Are you covered under Medicare? .... Part A: Yes ☐ No ☐ Part B: Yes ☐ No ☐
   If "Yes," give your Medicare card number. ______________ If "No," when will you become eligible? ____/____/____
   Mo. Day Yr.
2. Did you turn age 65 in the last 6 months?........ Yes ☐ No ☐
3. Did you enroll in Medicare Part B in the last 6 months? .... Yes ☐ No ☐
   If "Yes," indicate your effective date.____/____/____ If "No," indicate date you plan to enroll.____/____/____
   Mo. Day Yr. Mo. Day Yr.
4. Are you applying during a guaranteed issue period?........ Yes ☐ No ☐
   (**NOTE**: If the answer above is "Yes" please attach proof of eligibility.)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "Yes" or "No" with an "X" to the questions below.**

If you have had any other Medicare plan coverage as referenced below, not to include Medicare Supplement, please complete questions below (a-f) if not, skip to question #6.

5. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____

Name of Company	Kind of Policy	Policy/Certificate Number

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?........ Yes ☐ No ☐

(c) **If yes, have you received a copy of the replacement notice?**........ Yes ☐ No ☐

(d) Reason for termination/disenrollment? ______________

(e) Planned date of termination/disenrollment ____/____/____

(f) Was this your first time in this type of Medicare plan?........ Yes ☐ No ☐

(g) Did you drop a Medicare Supplement policy to enroll in this Medicare plan?........ Yes ☐ No ☐

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) .... Yes ☐ No ☐
   (a) If so, with what company and what kind of policy?

Name of Company	Kind of Policy

   (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. ____/____/____ (Mo. Day Yr.) **Have you received a copy of the Replacement Notice?** ..... Yes ☐ No ☐
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? .... ☐ ☐
   (b) Within the last ten years have you been diagnosed with or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? .... ☐ ☐
   (c) Within the last ten years have you been diagnosed with or treated for Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis? .... ☐ ☐
   (d) Within the last ten years have you been diagnosed with or treated for Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder? .... ☐ ☐
   (e) Within the last ten years have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .... ☐ ☐
   (f) Do you have diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (**including** high blood pressure) or kidney disease? .... ☐ ☐
   (g) Do you have diabetes that has ever required more than 50 units of insulin daily? .... ☐ ☐
   (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? .... ☐ ☐
   (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? .... ☐ ☐

	Yes	No
(j) Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis, or have you been advised to have a joint replacement?	☐	☐
(k) Have you been advised by a physician that surgery may be required within the next twelve months for cataracts?	☐	☐
(l) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐	☐
(m) Have you been hospital confined three or more times in the last two years?	☐	☐
(n) Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐	☐

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 **Originally** Prescribed	Frequency and Dosage	Diagnosis/Condition

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

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

(a) You do not need more than one Medicare Supplement policy.

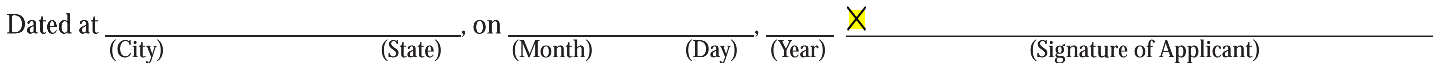
(b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.

(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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).



Dated at ______________________, on ________________, _____ X ______________________________

(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.

Carl Souders
Agent # 282102

______________________	______________________	______________________
(Signature of Licensed Producer) PRODUCER STAMP	(Signature of Licensed Producer) PRODUCER STAMP	(Signature of Licensed Producer) PRODUCER STAMP

ADDITIONAL INFORMATION: PART III - CON'T. HEALTH /MEDICAL QUESTIONS - Question #2.

Medication Name (copy off pharmacy label)	Date **Originally** Prescribed	Frequency and Dosage	Diagnosis/Condition

SECTION FOR ADDITIONAL COMMENTS:

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company or United World Life Insurance Company

Initial Premium Payment

Indicate ☐ Checking Account or ☐ Savings Account   Bank Name ______________________

Routing Number ______________________   Account Number ______________________
(First 9 digits on the lower left hand side of check)

Is this a business account? ☐ Yes ☐ No

I authorize Mutual of Omaha Insurance Company or United World Life Insurance Company to debit the bank account shown above for the first premium payment shown below at the time my application is processed. I understand the amount authorized for the initial premium payment may be different than the amount authorized for the renewal premium payment.

Initial Premium Payment Amount $__________________

Name as Shown on Account (please print)	
Authorized Signature as Shown on Account X	Date

If the person paying the initial premium payment is not the Applicant for insurance, please complete this section:

Joint Account or Other Authorized Name (please print)	
Joint Account or Other Authorized Signature	Date

Renewal Premium Payment

Complete the Bank Service Plan below and submit with the application if premium payments are to be withdrawn from your bank account.

Indicate ☐ Checking or ☐ Savings   Bank Name ______________________

Routing Number ______________________   Account Number ______________________
(First 9 digits on the lower left hand side of check)

Is this a business account? ☐ Yes ☐ No

Complete the following only if you are adding the above coverages to an existing BSP.

Name of Insured Under Existing BSP	Existing BSP Policy Number

Specify Date of Withdrawals   ☐ 1st of the Month   ☐ 15th of the Month

I authorize you to pay and charge my account any checks, drafts or preauthorized electronic fund transfer made upon my account by, and payable to the order of, Mutual of Omaha Insurance Company or United World Life Insurance Company. I agree that your rights with respect to each charge will be the same as if it were personally executed by me. This authorization is to remain in effect until I give you, and my financial institution, at least three business days' notice to revoke it, provided, however, if notice is given orally, then you may require a written confirmation from me within 14 days after the oral notification.

Name as Shown on Account (please print)	
Authorized Signature as Shown on Account X	Date

If the person paying the initial premium payment is not the Applicant for insurance, please complete this section:

Joint Account or Other Authorized Name (please print)	
Joint Account or Other Authorized Signature	Date

United World Life Insurance Company
A Mutual *of* Omaha Company

Authorization To Disclose Personal Information To United World Life Insurance Group

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, 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 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 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 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 below): ______________________________

____
Printed Name of Proposed Insured

X ______________________________
Signature of Proposed Insured

____
Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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) ____________________

____

____

1. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
2. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.
3. If, 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 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.

Carl E. Souders
Agent # 282102
____
(Signature of Agent, Broker or Other Representative)*

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

X ____________________ ____________________
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

1 - Home Office Copy 2 - Applicant Copy

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.

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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) ____

____

____

1. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
2. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.
3. If, 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 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.

Carl E. Souders
Agent # 282102
____
(Signature of Agent, Broker or Other Representative)*

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

X
____ ____________________________
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

1 - Home Office Copy 2 - Applicant Copy