

APPLICATION *for* - LONG TERM CARE



GEORGIA

LONG TERM CARE Application Submission Checklist



This application packet includes the application and state required forms.

Tear out and leave with the applicant the indicated forms

Submit the remainder of the packet intact with every question on the application and applicable forms completed. Unanswered questions or missing or incomplete forms 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 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”.

ADMINISTRATIVE APPENDIX FORMS

Privacy Authorization

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

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

Complete, sign and date if applicable

Payments will be deducted monthly on the date specified. Account information will be taken from the accompanying premium check. If no premium is submitted, attach a voided 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 applicant

Notice of Information Practices

Detach and leave with the applicant

Financial Institution Consumer Disclosure

If this insurance product or annuity is sold, solicited, advertised or offered to a customer at an office of the financial institution, or on behalf of the financial institution, the “Financial Institution Consumer Disclosure” form must be presented and signed at the time of application, and a copy provided with the submitted application.

Activities on behalf of a financial institution include activities where a person, whether at the office of the financial institution or at another location, sells, solicits, advertises, or offers an insurance product or annuity and at least one of the following applies:

- The person represents to a consumer that the sale, solicitation, advertisement or offer of any insurance product or annuity is by or on behalf of the financial institution,
- The financial institution refers a consumer to a seller of insurance products and annuities and the financial institution has a contractual arrangement to receive commissions or fees derived from a sale of an insurance product or annuity resulting from that referral, or
- Documents evidencing the sale, solicitation, advertising, or offer of an insurance product or annuity identify or refer to the financial institution.

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)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b | Did You have another long-term care policy or certificate in force during the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| c | Do You intend to replace other long-term care coverage or any of Your medical or health insurance coverage with this policy? | <input type="checkbox"/> | <input type="checkbox"/> |

If "Yes," please read and sign the replacement notice provided by the producer.

For Replacements only, Requested Effective Date of Coverage _____
 (Up to 60 days beyond application date.) Mo. Day Yr.
 (If issued, coverage will be effective on the date indicated here.)

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

Company Name/Address	Policy #	Type of Plan	Daily Benefit	Lapse Date	Annual Premium

- 2** Producers shall list all health insurance policies You have which are still in force _____
 _____ or None
- Producers shall list all health insurance policies they sold to You in the past five years, which are no longer in force
 _____ or None
- Producers shall list all health policies they sold to You which are still in force _____
 _____ or None

- | | | | |
|----------|---|--------------------------|--------------------------|
| | | Yes | No |
| 3 | Have You ever been declined, rated, or denied reinstatement for long-term care insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
- If "Yes," Name of Company _____
 When _____
 Why (if known) _____

C Health Insurability Questions

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1 Do You currently use any of the following: | <input type="checkbox"/> | <input type="checkbox"/> |
| • wheelchair | | |
| • electric scooter | | |
| • walker | | |
| • quad cane | | |
| • nebulizer | | |
| • oxygen | | |
| 2 Within the past 6 months have You been confined to a/an, or been advised to have..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • residential care facility | | |
| • adult day care facility | | |
| • nursing home | | |
| • assisted living facility | | |
| • home health care services | | |
| • physical therapy | | |
| • occupational therapy | | |
| • speech therapy | | |
| 3 Do You require the assistance or supervision of another person or a device of any kind for any of the following: | <input type="checkbox"/> | <input type="checkbox"/> |
| • bathing | | |
| • dressing | | |
| • eating | | |
| • medication management | | |
| • toileting | | |
| • getting in and out of a chair or bed | | |
| • Your inability to control Your bowel or bladder | | |
| 4 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)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Within the last 10 years, have You been diagnosed or treated by a member of the medical profession as having Diabetes and do You 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Within the past 10 years, have You been diagnosed or treated by a member of the medical profession as having Diabetes and have You had a Stroke/Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Within the last 10 years, have You been medically diagnosed as having, or received medical care for any of the following: | <input type="checkbox"/> | <input type="checkbox"/> |
| • Alzheimer's Disease | | |
| • Dementia | | |
| • Memory Loss | | |
| • Mental Retardation | | |
| • Schizophrenia | | |
| • Psychosis | | |
| • Alcohol or Drug Use | | |
| • Amputation due to disease | | |
| • Chronic Hepatitis | | |
| • Cirrhosis | | |
| • Kidney Failure or received Dialysis | | |
| • Parkinson's Disease | | |
| • Multiple Sclerosis | | |
| • Muscular Dystrophy | | |
| • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past 12 months | | |
| • Amyotrophic Lateral Sclerosis (ALS) | | |
| • Huntington's Chorea | | |
| • Myasthenia Gravis | | |
| • Paralysis | | |
| • Scleroderma | | |
| • Systemic Lupus | | |
| 9 Have You been diagnosed or treated by a member of the medical profession as having 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 In the past 2 years have You been diagnosed with Cancer or received treatment for Cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| (Except basal and squamous cell skin cancers; stage I/A breast, bladder, prostate or thyroid cancers.) | | |
| 11 Have You ever had an Organ Transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 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? | <input type="checkbox"/> | <input type="checkbox"/> |

STOP – If You answered “Yes” to any of the questions 1 through 12 of Section C above do not continue further. We will be unable to accept this application or offer You Long-Term Care insurance.

If You answered “No” to every question, please continue.

NOTE: Even though we cannot accept Your application if You answered “Yes” to any of questions 1 through 12 of Section C above, Your spouse may qualify to add the “Spouse Benefit” to his/her application.

E Health Questions

- | | | |
|---|--|--|
| | Yes | No |
| 1 Within the last 10 years, have You been diagnosed or treated by a physician or health care provider for: | <input type="checkbox"/> | <input type="checkbox"/> |
| Check all that You are answering as Yes – | | |
| <input type="checkbox"/> Stroke or Transient Ischemic Attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Circulatory Disease/Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Heart Disease/Disorder | <input type="checkbox"/> Depression/Other Mental Disorder | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Respiratory Disease/Disorder | <input type="checkbox"/> Seizures, Epilepsy, Tremors | <input type="checkbox"/> Dizziness or Fainting |
| <input type="checkbox"/> Kidney or Liver Disease/Disorder | <input type="checkbox"/> Neurological Disease/Disorder | <input type="checkbox"/> Balance Disorder or |
| <input type="checkbox"/> Immune System Disease/Disorder | <input type="checkbox"/> Bowel or Bladder Disease/Disorder | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Anemia or Blood Disease/Disorder | <input type="checkbox"/> Arthritis, Bone or Joint Disorder | <input type="checkbox"/> Weakness or Fatigue |
| 2 Have You received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Are there any pending test results which You have not yet received? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Have You been seen by Your physician, health care provider or any specialists more than three times in the past 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Have You obtained a handicap sticker or handicap license plate? | <input type="checkbox"/> | <input type="checkbox"/> |

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 #

G Notice Before Lapse or Termination

Please complete the following applicable box, sign and date.

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 Home 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.

X _____
Signature of Proposed Insured

Date _____
Mo. Day Yr.

H Agreements

Agreement – I, the undersigned, and the undersigned Producer(s), agree that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely upon these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.

If the full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for, in accordance with the health and accident underwriting standards of Mutual of Omaha Insurance Company in effect on the date of the application, the effective date of the policy will be the date of the application, or, if later, the expiration of any replaced coverage. **I agree that no temporary or interim insurance of any kind will be in effect.**

The underwriting standards of Mutual of Omaha Insurance Company will not be applied to changes in health after the application date unless a medical examination (including a personal health interview) or medical test is required. In order for the policy applied for to be issued, all required medical examinations and tests must be completed, and Mutual must receive the reports from all required medical examinations and tests, and any other information (such as an Attending Physician’s Statement) that is requested. If all of these requirements are met, the underwriting standards of Mutual of Omaha Insurance Company will not apply to changes in health after the application date. **If I am not eligible for the insurance applied for or any substitute policy, I agree that no policy of any kind will be in effect.**

No Producer can: (a) waive or change any receipt or policy provision or (b) agree to issue a policy.

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 Protection option. Specifically, I have reviewed options for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation 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.

_____ **Initials of Proposed Insured**

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**

I acknowledge receipt of, if applicable:

- Outline of Coverage
- Long-Term Care Insurance Personal Worksheet
- Privacy Notice
- Shopper’s Guide to Long-Term Care Insurance
- Guide to Health Insurance for People with Medicare
- Potential Rate Increase Disclosure Form

FRAUD WARNING – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

I have read and understand the Agreement and Fraud Warning Sections and the Receipt provided, and I have read and approve all my answers as recorded in this application.

Signed at _____ Date _____
City State Mo. Day Yr.

X _____
Signature of Proposed Insured

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 _____
Signature of Licensed Producer

X _____
Signature of Licensed Producer

Office Name

Office Name

Office Address

Office Address

Appendix 1 Authorization To Disclose Personal Information To Mutual of Omaha 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 Mutual of Omaha 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 Rediscovery

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
Mutual of Omaha 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 Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha 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
_____ Signature of Proposed Insured	_____ Signature of Spouse (If Proposed Insured)	_____ Signature of Parent or Guardian (If Proposed Insured is a Minor)
_____ Date	_____ Date	_____ Date

Appendix 4 Producer Statement

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1 I/We certify that the Notice of Information Practices was given to the Proposed Insured. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |

(If "No," explain) _____

Date _____ Signature of Producer _____

Date _____ Signature of Producer _____

Producer Information

Producer's Name _____ Social Security No. _____

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

Producer's E-mail Address _____

Mgr./Marketer Phone Number (____) _____

Producer's Stamp _____ Producer's License/Identification # _____

Producer's Name _____ Social Security No. _____

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

Producer's E-mail Address _____

Mgr./Marketer Phone Number (____) _____

Producer's Stamp _____ Producer's License/Identification # _____

Who should we contact with questions regarding this pending application: Name _____ Phone Number (____) _____ E-mail _____

Appendix 5 Receipt

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

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

Received from _____ the sum of \$ _____ paid as the full initial premium with the attached Long-Term Care Insurance application to Mutual of Omaha Insurance Company.

Notice to Applicant: Eligibility for the insurance applied for, or for any substitute policy issued from this application, is subject to the following:

- 1 Written application.
- 2 Payment of the full initial premium.
- 3 Completion by the Proposed Insured of all examinations and tests (medical, paramedical, laboratory, personal health interview) required by Mutual of Omaha Insurance Company.
- 4 Receipt by Mutual of Omaha Insurance Company of any additional information (such as an Attending Physician's Statement) requested for underwriting.
- 5 Satisfying Mutual of Omaha Insurance Company underwriting standards.

If the Proposed Insured is eligible, the effective date of the insurance for that Proposed Insured will be the date of the application, or the date the number of applications received from members of Your group meets the minimum participation requirements, whichever date is later. **If the Proposed Insured, is not eligible, no insurance or temporary or interim insurance of any kind will be in effect for the Proposed Insured.**

Should Mutual of Omaha Insurance Company decline to issue the insurance applied for, I understand that the above sum will be returned to the Proposed Insured.

Date _____
Mo. Day Yr. Signature of Producer

Appendix 6 Mutual of Omaha 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: MUTUAL OF OMAHA INSURANCE COMPANY, LONG-TERM CARE SERVICE OFFICE, P.O. BOX 64901, ST. PAUL, MN 55164-0901.

Remove This Page and Leave With Proposed Insured

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



Mutual of Omaha 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 Mutual of Omaha 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 Agent

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 agent 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.

Agent's Signature

Typed Name and Address of Agent

The above Notice to Applicant was delivered to me on:

Date

Applicant's Signature

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



Mutual of Omaha 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 Mutual of Omaha 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 Agent

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 agent 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.

Agent's Signature

Typed Name and Address of Agent

The above Notice to Applicant was delivered to me on:

Date

Applicant's Signature

Long-Term Care Insurance Personal Worksheet

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



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) _____

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 1987 and has sold this policy form since 2004. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	Rate History
NH23/NH24	1988-1993	No Rate Increase
LTC1/LTM1	1992-1997	No Rate Increase
LT50	1997-2004	No Rate Increase
NHA/LTA/HCA	1998-2004	23% overall rate increase 2003
LTC04	2004-Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals would vary by state.

*Or state equivalent.

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 \$16-29,999 Over \$50,000
 \$10-15,999 \$30-50,000

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 2002 was \$61,320, but this figure varies across the country. In ten years the national average annual cost would be about \$99,884 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

<input type="checkbox"/> The answers to the questions above describe my financial situation.	<input type="checkbox"/> I choose not to complete this information.
--	---

I acknowledge that the carrier and/or its agent (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: _____ (Applicant) _____ (Date)

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

Signed: _____ (Agent/Producer) _____ (Date)

Agent's/Producer's Printed Name: _____

My agent/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: _____ (Applicant) _____ (Date)

The company may contact you to verify your answers.

LONG-TERM CARE INSURANCE APPLICATION PROCESSING AUTHORIZATION

My agent has explained to me the importance of completing the Long-Term Care Insurance Personal Worksheet. I understand that my personal financial situation is an important consideration in determining whether the purchase of Long-Term Care Insurance is appropriate for me.

I have received a copy of the *“Things You Should Know Before You Buy Long Term Care Insurance”* from my agent.

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 _____ Dated _____
(Applicant)

NOTE: This must be submitted with the application and the Long-Term Care Insurance Personal Worksheet, when the applicant elects not to complete the Worksheet.



Long Term Care Insurance Potential Rate Increase Disclosure Form

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.)

Turn the Page

***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 a least \$10,000 of benefits remaining under your policy.)

Turn the Page

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



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 agent 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.

Conversion Offer

I understand that I have been given the opportunity to exchange my Mutual of Omaha 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 Return of Premium Rider, 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 Mutual of Omaha 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: _____ Date: _____

Agent Signature: _____ Date: _____

Agent Copy

M21005_0803

Conversion Offer

I 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 Mutual of Omaha 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: _____ Date: _____

Agent Signature: _____ Date: _____

Customer Copy

M21005_0803

Georgia Long-Term Care Certification



I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. _____

offered by the Mutual of Omaha Insurance Company to _____ (applicant).

THAT, I have explained to the applicant the provisions of the long-term care policy applied for, specifically including all of the different benefits, exceptions and limitation of the coverage.

THAT, I am a properly licensed insurance agent in the State of Georgia, authorized to represent the above-named insurance company, and that I have given a company receipt to the applicant for an initial premium in the amount of \$_____ (insert zero if no premium received), which has been paid by () Check () Money Order () Bank Draft made payable only to the insurance company. (DO NOT ACCEPT CASH.) In the event the applicant's application is not approved, the above-named insurance company shall be responsible for the immediate and full refund of any premium to be returned to the applicant.

THAT, I have clearly explained to the applicant that this long-term care insurance is not Medicare supplement insurance, and that Medicare only provides limited skilled nursing care for Medicare eligible persons.

THAT, I have asked whether the applicant is currently insured under any existing long-term care insurance policy or any other accident and sickness insurance policy, individual or group, and if so, the name(s) of the insurer(s), type(s) of policy or policies and policy number(s) of such coverage is(are) as follows:

_____	_____	_____
(Name of Company)	(Type of Policy)	(Policy Number)
_____	_____	_____
(Name of Company)	(Type of Policy)	(Policy Number)
_____	_____	_____
(Name of Company)	(Type of Policy)	(Policy Number)

THAT, I have not made any representation to the applicant that the Social Security Administration or any other state or federal government agency has made any endorsement whatsoever in connection with the policy applied for.

_____	_____
(Date)	(Signature of Agent)

Name and Address of Agency, Branch Office of District Office, if different from Agent's Business Address:

Business Address of Agent and Phone Number:

_____	_____
_____	_____
_____	_____
_____	_____

DO NOT SIGN THIS CERTIFICATION UNLESS ALL ITEMS HAVE BEEN COMPLETED AND SIGNED BY THE AGENT.

I, the undersigned applicant, have received the Georgia Buyer's Guide for long-term care insurance, the Outline of Coverage for the policy for which I have applied, and the Notice to Applicant Regarding Replacement if a replacement is occurring.

_____ (Applicant's Signature)

ORIGINAL TO APPLICANT — COPY TO INSURER

Georgia Long-Term Care Certification



I, the undersigned insurance agent certify:

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_____	_____	_____
(Name of Company)	(Type of Policy)	(Policy Number)
_____	_____	_____
(Name of Company)	(Type of Policy)	(Policy Number)
_____	_____	_____
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_____	_____
(Date)	(Signature of Agent)

Name and Address of Agency, Branch Office of District Office, if different from Agent's Business Address:

Business Address of Agent and Phone Number:

_____	_____
_____	_____
_____	_____
_____	_____

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ORIGINAL TO APPLICANT — COPY TO INSURER