



## Medicare Supplement Application Submission Checklist

**NOTE: 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.**

[    ]    **Application**

1. Must be taken during an in-person interview (cannot mail or complete via phone).
2. Answer all questions in full.
3. Be sure to leave all applicable forms with the proposed insured.
4. Sign and Date in all places indicated.
5. See reverse side of this page for additional detailed information.

[    ]    **Collect Premium Amount**

The full modal premium\* is collected at the time of application.

\*In California and New Hampshire collect **one** month only.

[    ]    **Provide Client with Buyer’s Guide**

[    ]    **Provide Client with Outline of Coverage**

[    ]    **Provide Client with Official Receipt signed by agent**

[    ]    **Attach Replacement Notice and leave a copy with the applicant (if applicable)**

[    ]    **Comments, Additional Information, Attach State Specific Form(s), please list**

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**DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION**

**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 (Certificate) Form
  - Requested Effective Date
  - Rider No. (**MN & WI** only)
  - Premium Initial (Amount — CA and NH one month only)
  - Premium Paid (Amount of Check Attached)
  - Initial Mode\* (**A**=Annual, **S**=Semiannual, **Q**=Quarterly, or **B**=Bank Service Plan)
  - Renewal Premium (Amount)
  - Renewal Date (not required)
  - 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 “Health/Other 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 can provide this number by calling 1-800 775-1000 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                      – Termination/Disenrollment Date
  - Policy Number                         – Issue Date
  - Policy Type

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

## **2. Administrative Forms**

### **Authorization to Withdraw Funds by Mutual of Omaha Insurance Company (BSP) — 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.

### **Producer Information**

- Be sure to include you Social Security number and commission code. This is necessary information for the underwriting process and commission payment.
- Include your telephone number and e-mail address — if applicable.

### **Receipt**

- Detach and leave with applicant.

### **State – Specific Forms**

- Be sure to include all state appropriate forms.

Mgr./Commission Code (Required Field For Brokerage)		District Sales Manager/Assoc. Marketer	Application Reviewed By
<b>Plan Information</b> (to be completed by Producer)			
Policy(Certificate) Form		Requested Effective Date:	
Rider No.			
Spouse applying for coverage (different application)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Premium-Initial \$	Premium Paid \$	Initial Mode A, S, Q or B	
Renewal \$	Renewal Date	Renewal Mode A, S, Q or B	



## Application to Mutual of Omaha Insurance Company for Medicare Supplement Coverage

### Part I. General Information

- Print Name \_\_\_\_\_ Home Phone No. (\_\_\_\_\_) \_\_\_\_\_  
(Title) (First) (Middle) (Last) (Area Code)
- Residence Address \_\_\_\_\_  
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Mailing Address \_\_\_\_\_  
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex: M  F  Height \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight \_\_\_\_\_ Lbs.  
Mo. Day Yr. (current age)
- Social Security No. \_\_\_\_\_ E-mail Address: \_\_\_\_\_
- Are you a citizen of the U.S.?  Yes  No If "No," do you have an alien registration receipt "Permanent Visa"?  Yes  No  
 Permanent Visa No. \_\_\_\_\_ Date of arrival in the United States \_\_\_\_\_  
(Mo.) (Yr.)
- Have you received a copy of the *Guide to Health Insurance for People with Medicare*? .....  Yes  No
- Have you received the required Outline of Coverage? .....  Yes  No
- Have you used tobacco in any form in the past 12 months? .....  Yes  No

### Part II. Health/Other Information (complete in full)

- 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.
- Have you enrolled in Medicare Part B? .....  Yes  No  
 If "Yes," indicate your effective date. \_\_\_\_\_ If "No," indicate date you plan to enroll. \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.
- Are you applying during a guaranteed issue period? .....  Yes  No  
 (NOTE: If the answer above is "Yes" please attach proof of eligibility.)

- 4. Health Questions: If the answer is "Yes" to any of the following questions (a)-(m), 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 (a)-(m).) Yes No**
- Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? .....  Yes  No
  - Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? .....  Yes  No
  - Have you been diagnosed with Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis? .....  Yes  No
  - Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder? .....  Yes  No
  - Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....  Yes  No
  - Do you have diabetes that ever requires more than 50 units of insulin daily, or do you have diabetes with diabetic retinopathy, peripheral vascular disease, neuropathy or heart or kidney disease? .....  Yes  No
  - 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? .....  Yes  No
  - 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
  - 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? .....  Yes  No
  - Have you been advised by a physician that surgery may be required within the next twelve months for cataracts? .....  Yes  No
  - Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ....  Yes  No
  - Have you been hospital confined three or more times in the last two years? .....  Yes  No
  - Have you had an organ transplant or been advised by a physician to have an organ transplant? .....  Yes  No

Yes No

5. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? .....   If "Yes," please list the drug and the condition. (Attach a separate signed sheet, if necessary.)

Table with 4 columns: Medication Name (copy off pharmacy label), Date Originally Prescribed, Frequency and Dosage, Diagnosis

6. To the best of your knowledge, do you have another Medicare supplement insurance policy or certificate in force? ...   (a) If "Yes," with which company?

Table with 5 columns: Name of Company, Policy/Certificate Number, Part A (Yes/No), Part B (Yes/No), Issue Date

(b) If "Yes," do you intend to replace your current Medicare supplement policy or certificate with this policy/certificate? ....   If "Yes," indicate termination date. \_\_\_\_\_ Have you received a copy of the Replacement Notice? .....

7. To the best of your knowledge: (a) Do you have (or in the last 63 days, have you had) any other health insurance/coverage that provides benefits similar to this Medicare supplement policy/certificate? .....   (b) Have you been covered by any other health insurance/coverage within the last 63 days? .....   (i) If (a) or (b) "Yes," with which company? (ii) What kind of policy or certificate (e.g., Hospital, Medical, HMO)?

Table with 5 columns: Name of Company, Policy/Certificate Type, Issue Date, Paid-to-Date, Description of Benefits

(c) Reason for termination/disenrollment? \_\_\_\_\_ (d) Date of termination/disenrollment \_\_\_\_\_

8. To the best of your knowledge, are you covered for medical assistance through the state Medicaid program: (a) As a Specified Low Income Medicare Beneficiary (SLMB)? .....   (b) As a Qualified Medicare Beneficiary (QMB)? .....   (c) For other Medicaid medical benefits? .....

9. To be completed by the producer(s): List any other health insurance (including any policies/certificates listed in #6 and #7 above) sold to the applicant by you, the producer(s) signing this application, that are:

(a) Still in force? Table with 4 columns: Name of Company, Policy(Certificate) Number, Description of Benefits, Effective Date of Coverage

(b) No longer in force and which was sold within the past five years? Table with 4 columns: Name of Company, Policy(Certificate) Number, Description of Benefits, Effective Date of Coverage

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

Important Statements To Be Read By Applicant

- (a) You do not need more than one Medicare supplement policy/certificate. (b) If you purchase this policy/certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy/certificate. (d) The benefits and premiums under your Medicare supplement policy/certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. (e) 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 \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ (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

## Trust Affiliation

(Complete only if M500 series are being sold — i.e., M500, M501, M502 or state special version)

Mutual of Omaha Insurance Company and/or its Affiliates (Insurer) are authorized to issue insurance plans to the Direct Marketer's Insurance Trust (hereinafter called Trust). For the sole purpose of obtaining the said insurance plan or plans issued to the Trust, the Proposed Insured (named below) hereby affiliates with the Trust.

\_\_\_\_\_  
(Proposed Insured Signature)

\_\_\_\_\_  
(Mutual of Omaha Insurance Company Representative)

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

\_\_\_\_\_  
(Office)

## Producer(s) Information

Producer Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Comm. % Share: \_\_\_\_\_ Producer Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Commission Code: \_\_\_\_\_

Producer E-mail Address: \_\_\_\_\_ @ \_\_\_\_\_

Producer Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Comm. % Share: \_\_\_\_\_ Producer Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Commission Code: \_\_\_\_\_

Producer E-mail Address: \_\_\_\_\_ @ \_\_\_\_\_

Producer Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Comm. % Share: \_\_\_\_\_ Producer Phone No. ( \_\_\_\_\_ ) \_\_\_\_\_ Commission Code: \_\_\_\_\_

Producer E-mail Address: \_\_\_\_\_ @ \_\_\_\_\_

(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

Is the applicant:

**Yes No**

(a) unemployed?.....

(b) employed, but not working for the business that is paying the premium? .....

(c) the business owner or spouse of the business owner? .....

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

**ATTENTION READ CAREFULLY**

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

**How To Sign up for the Bank Service Plan**

- 1. Complete the form, making sure to write your name as shown on your checking account.
- 2. Include your check for the first month's payment with your completed form. We'll use the account number on your check to put your monthly Bank Service Plan payments into effect. So it's important your check is from the account you want your payments withdrawn from.

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

\_\_\_\_\_ Insured Under Existing BSP \_\_\_\_\_ Existing BSP Policy Number

Specify Date of Withdrawals:     1st of the month.     15th of the month.

**Important! Fill in and return if you want your bank to make monthly insurance payments for you.**

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY, Omaha, Nebraska. As a convenience to me, I authorize you to pay and charge to my account any checks, drafts or preauthorized electronic fund transfers made upon my account by, and payable to the order of, Mutual of Omaha 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, 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.

\_\_\_\_\_ **X** \_\_\_\_\_  
(Date) (Authorized Signature as Shown on Account)

\_\_\_\_\_ **X** \_\_\_\_\_  
(Joint Account or Other Authorized Signature)

Your premiums will be withdrawn monthly from your checking account on the date you've checked above.

**Detach, complete in full and leave with applicant at time of application.**

**OFFICIAL RECEIPT**

**Cash or Check Application**

All premiums must be made payable to the Company.  
**Do not make checks payable to the agent or leave the payee blank.**



Received of \_\_\_\_\_ this \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_ an application for a Form \_\_\_\_\_ Policy and Riders \_\_\_\_\_  
\_\_\_\_\_ and Cash or Check 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.**