Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By

Critical Illness Insurance Application

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

☐ **Addition to Existing Coverage**
_____
(Policy Number)

Application for policy form(s)
☐ CI
☐ CI1

Section A General Questions

1 Proposed Insured's Name _____
First Middle Last

2 Home Phone Number (_____) _____ State of Birth _____
Area Code

3 Legal Residence Address _____
Number Street City State ZIP Code

E-mail Address _____

4 Mailing Address for Premium Notices _____
Number Street City State ZIP Code

5 Is each person proposed for insurance a citizen of the United States? ..... ☐ Yes ☐ No
If "No," do all non-citizens have an alien registration receipt "Permanent Visa"? ..... ☐ Yes ☐ No

If "Yes," Name _____ Permanent Visa Number _____ Date of arrival in United States _____

If "Yes," Name _____ Permanent Visa Number _____ Date of arrival in United States _____

6 Occupation _____ Duties _____

Your Income _____ Spouse's Income _____ Household Income _____ Mortgage Balance _____
Are you currently engaged in your occupation on an active full-time basis (30 or more hours per week)? ☐ Yes ☐ No
(If "No," explain including date of last full-time work.)

_____

Name of your firm or employer and address _____

Work Phone Number (_____) _____
Area Code

Spouse's Occupation _____ Spouse's Duties _____

Is your spouse currently engaged in his/her occupation on an active full-time basis (30 or more hours per week)?
☐ Yes ☐ No (If "No," explain including date of last full-time work.)

_____

Name of spouse's firm or employer and address _____

7 Please complete for all persons proposed for insurance.

Name (First/Middle/Last)	Social Security Number	Relationship to Proposed Insured	Birth Date Mo./Day/Yr.	Age	Sex	Ht.	Wt.
		Self					
		Spouse					

Section B Underwriting Information

1 During the past 10 years, has any person proposed for insurance been diagnosed or treated by a member of the medical profession for any disease or disorder of the following: (Check all that apply. Provide explanation for all checked boxes in number 9.)

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Back Disorder
☐ Breast Disease or Disorder
☐ Cancer
☐ Diabetes
☐ Digestive Disorder
☐ Eye or Ear Disorder
☐ Heart Disease
☐ High Blood Pressure
☐ Kidney Disorder
☐ Liver Disorder
☐ Major Organ Transplant
☐ Multiple Sclerosis
☐ Psychiatric condition
☐ Paralysis or Numbness
☐ Prostate Disorder
☐ Respiratory Disorder
☐ Stroke or TIA (Transient Ischemic Attack)
☐ Tumor, Polyp or Growth
☐ **None of These**

Section B — Underwriting Information (Continued)

2 Has any person proposed for insurance ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ..... ☐ Yes ☐ No
(If "Yes," explain in number 9.)
California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

3 During the past 10 years, other than shown in B1 and B2, has any person proposed for insurance: (Check all that apply. Provide explanation for all checked boxes in number 9.)
☐ Been diagnosed or treated by a health care provider (including a Medical Doctor, Chiropractor, Psychologist, Podiatrist or other health care professional)?
☐ Had or been advised to seek treatment for any illness, injury or disorder?
☐ Had surgery?
☐ Been hospitalized?
☐ Had a medical examination, diagnostic or medical evaluation or received medical care?
☐ **None of These**

4 ~~Have any proposed insureds' natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age 60~~ **with any of the conditions** ~~from the following list?~~
~~Diabetes, heart disease, stroke, kidney disease or cancer (other than skin cancer)?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If "Yes," please provide details below.~~

~~Person Proposed For Insurance~~	~~Family Member/Relationship~~	~~Diagnosis~~	~~Age at Time of Diagnosis~~

5 (a) Within the past six months, has any person proposed for insurance taken any prescription medication? .... ☐ Yes ☐ No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Medication Name (Copy From Pharmacy Label)	Dosage/ Frequency	Date	Prescribing Physician	Phone Number	Reason

(b) Within the past six months, has any person proposed for insurance taken any over-the-counter drugs on a regular basis? ..... ☐ Yes ☐ No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Medication Name	Dosage/Frequency	Reason

6 During the past 12 months, has any person proposed for insurance used:
(a) any form of tobacco? ..... ☐ Yes ☐ No
(b) any form of nicotine replacement therapy (for example – nicotine gum, patch or spray)? ..... ☐ Yes ☐ No
If you answered "Yes" in 6 (a) or (b), please provide details below.

Person Proposed For Insurance	What Form	Number Per Day	Stopped On

7 During the past 10 years, has any person proposed for insurance used unlawful drugs in any form (including cocaine and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? ..... ☐ Yes ☐ No
(If "Yes," provide explanation in number 9.)

8 Is any person proposed for insurance pregnant? ..... ☐ Yes ☐ No
If "Yes," history of complications? ..... ☐ Yes ☐ No
(If "Yes," provide explanation in number 9.)

9 Complete this section to provide additional information on questions 1, 2, 3, 7 and 8 in Section B. (Attach a separate signed sheet if necessary.)

Person Proposed For Insurance	Condition(s)	Provider, City/State	Phone Number

Section C — Plan Information (Availability of plan and riders is subject to change.)

Complete for Proposed Insured	Yes	No	Complete for Spouse (if a Proposed Insured)	Yes	No
Base Policy Benefit Amount $_____			Base Policy Benefit Amount $_____		
Accidental Death & Dismemberment Benefit Rider	☐	☐	Accidental Death & Dismemberment Benefit Rider	☐	☐
AD&D Benefit Rider Amount $_____			AD&D Benefit Rider Amount $_____		
Disability Benefit Rider	☐	☐	Disability Benefit Rider	☐	☐
Hospital Confinement Benefit Rider	☐	☐	Hospital Confinement Benefit Rider	☐	☐
Premium Collected $ _____			Premium Collected $ _____		
Renewal Premium $ _____			Renewal Premium $ _____		

Billing Mode ☐ BSP ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PRD

Section D — Other Coverage Information

1 Does any person proposed for insurance currently have, or is such person applying for, Critical Illness (lump-sum diagnostic benefits) coverage with any company? ☐ Yes ☐ No

If "Yes," give details including the name(s) of such person(s), name of the company, policy/plan number and termination date. _____

_____

2 Does each person proposed for insurance have comprehensive health insurance/HMO coverage in force? ☐ Yes ☐ No

If "No," that person does not qualify for the Critical Illness coverage.

3 Is any person proposed for insurance purchasing this insurance to replace any existing insurance? ☐ Yes ☐ No

(a) If "Yes," give details, including the name(s) of such person(s), name of the company, policy/plan number and termination date. _____

_____

(b) If "Yes," has each person proposed for insurance received a copy of the Notice of Replacement (if required in your state)? ☐ Yes ☐ No

4 Is any person proposed for insurance eligible for, or receiving benefits from, Medicare or Medicaid? ☐ Yes ☐ No

If "Yes," please provide name(s) of individual(s) and details. _____

_____

5 Has each person proposed for insurance received the appropriate Outline/Summary of Coverage? ☐ Yes ☐ No

6 **Complete only for Association or Franchise Coverage**

I/We belong to the _____ Date joined _____
(Full Name of Organization) (Mo.) (Yr.)

7 Full name of your beneficiary _____

Relationship _____

8 If the spouse is a proposed insured, the full name of spouse's beneficiary _____

Relationship _____

Section E Agreement & Fraud Warning

Agreements – I/We, 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. I understand that to apply for this coverage the Proposed Insured must be covered by an individual or group policy or contract that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans.

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.

In order for Mutual of Omaha Insurance Company to issue a policy as a result of this application, (a) the person proposed for insurance must complete all required examinations and tests (medical, paramedical, laboratory), and (b) Mutual of Omaha Insurance Company must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician's Statement) that it requires, and (c) the application must be approved for issue by Mutual of Omaha's Underwriting Department. If all of these requirements are met, the underwriting standards of Mutual of Omaha will not apply to changes in health after the application date. **If a person proposed for insurance is not eligible for the insurance applied for, or any substitute policy, I/We agree that no policy of any kind will be in effect except for coverage provided by any Temporary Insurance Health and Accident Insurance Agreement.**

I have received the Notice of Information Practices and the MIB Group, Inc. Pre-Notice.

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

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.

I/We have read and understand this Agreement Section and any Receipt provided, and I/we approve all the answers as recorded in this application.

Signed at _____ Date _____
(City) (State)

_____ _____
Signature of Proposed Insured Signature of Spouse (If Proposed for Insurance)

I/We, the Producer(s), also certify that, during an in-person interview with the person(s) proposed for insurance, I/we asked each question exactly as written and recorded the answers provided by the person(s) proposed for insurance completely and accurately. ☐ Yes ☐ No

(If "No," please explain.) _____

_____

X_____ X_____
Producer's Signature Producer's Signature

_____ _____
(Date) Mo./Day/Yr. (Date) Mo./Day/Yr.

_____ _____
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 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
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

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Appendix 2 Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

Meanings of Terms

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

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

"Specified Companies" means:

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

Authorization to Receive and Disclose

To the MIB:

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

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

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

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

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

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

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

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

_____

_____

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Spouse (If Proposed Insured) Date

_____ _____
Signature of Parent or Guardian (If Proposed Insured is a Minor) Date

Appendix 3 — Producer Statement

1 Do you have any reason to believe any policy applied for has replaced or will replace any existing insurance? (If "Yes," fulfill all state requirements.) ☐ Yes ☐ No

2 Has a medical examination of the person(s) proposed for insurance been scheduled? ☐ Yes ☐ No
If "Yes," when? _____ By _____

3 If benefit amounts $100,000 or more, has the client profile interview(s) been completed? ☐ Yes ☐ No
If "No," the client profile interview(s) has/have been scheduled for _____ (Date) and _____ (Time (Please circle – Eastern, Central, Mountain or Pacific))

4 Did you give the Notice of Information Practices and the MIB Group, Inc. Pre-Notice to the Proposed Insured(s)? ☐ Yes ☐ No

Date _____ (Mo./Day/Yr.) _____ (Producer's Signature) _____ (Producer's Signature)

Producer Information: John M. Caris / Sonoma Valley Insurance Agency, Inc.

Producer Name _____ Producer Social Security Number _____

Comm. % Share _____ Producer Phone Number (707) 935-6294 x103 (Area Code)

Producer Stamp _____ Producer License/ID Number 0F82712

Producer E-mail Address jcaris@carisagency.com

Producer Name _____ Producer Social Security Number _____

Comm. % Share _____ Producer Phone Number (_____) _____ (Area Code)

Producer Stamp _____ Producer License/ID Number _____

Producer E-mail Address _____

Appendix 4 — Authorization to Withdraw Funds By Mutual of Omaha Insurance Company

I List the policies to be paid by your checking account:

(1) _____ (Form) _____ (Proposed Insured) (3) _____ (Form) _____ (Proposed Insured)

(2) _____ (Form) _____ (Proposed Insured) (4) _____ (Form) _____ (Proposed Insured)

II Complete the following only if you are adding the above coverages to an existing Bank Service Plan (BSP) account.

_____ (Insured Under Existing BSP) _____ (Existing BSP Policy/Certificate Number)

III Specify the date premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

IV Attach your check from the account from which premiums will be withdrawn.

As a convenience to me, I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha Insurance Company listed above. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Date _____ (Mo./Day/Yr.) X _____ (Authorized Signature as Shown on Account) X _____ (Joint Account or Other Authorized Signature)

Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

United of Omaha Life Insurance Company
Mutual of Omaha Life Insurance Company

To evaluate your Insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done.

The HIV Antibody Test — Description and Purpose of the Test

A series of tests will be performed by a licensed laboratory through a medically accepted procedure to determine whether you may have been infected with the HIV virus. This test is not a test for acquired immunodeficiency syndrome (AIDS). AIDS is a disease you get when HIV destroys your body's immune system, and can only be diagnosed by medical evaluation.

An initial ELISA blood test will be done. If the initial ELISA test is positive, then a repeat ELISA test will be performed. If the second ELISA test is positive, a Western Blot test will be conducted to confirm the positive ELISA test results.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Potential Uses and Disclosure of Test Results

Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application.

Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, urine or oral specimen test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood or oral specimen.

Limitations

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus.

Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous three to six months.

Counseling

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or your own health care provider. A list of counseling resources is provided for your information.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician _____

Address _____

Consent

I have read and I understand this Notice and Consent form. I voluntarily consent to testing as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date _____

_____
Signature of Proposed Insured or Parent/Guardian

Appendix 5 — 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, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Appendix 6 — Mutual of Omaha Insurance Company
MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is: Post Office Box 105, Essex Station, Boston, MA 02112.

Mutual of Omaha Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Appendix 7 — Mutual of Omaha Insurance Company
Investigative Consumer Reports Notice

Mutual of Omaha Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

Remove Notices and Give to Proposed Insured

Appendix 8 Temporary Health and Accident Insurance Agreement and Receipt ("Agreement")

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

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.

Policy form (rider) applied for _____

In consideration of the application and payment of $ _____ by the Proposed Insured(s), receipt of which is hereby acknowledged, Mutual agrees to provide limited temporary health and accident insurance for the Proposed Insured(s) named on the application, subject to the following conditions and limitations:

1 The temporary insurance provided by this Agreement will begin at 12:01 a.m., Standard Time where the Proposed Insured(s) live(s), on the latest of these dates:
(a) The date the above sum is received; or
(b) The date the application is signed by the Producer(s) and Proposed Insured(s); or
(c) The date this Agreement is signed by the Producer(s) and Proposed Insured(s).

2 The temporary insurance provided by this Agreement will automatically terminate as to a Proposed Insured at 12:01 a.m., on the same Standard Time, on the earliest of the following dates:
(a) 90 days from the date of this Agreement; or
(b) the date that insurance takes effect under the policy applied for; or
(c) the date a policy, other than as applied for, is offered to the Proposed Insured; or
(d) the date Mutual mails the premium refund and letter informing the Proposed Insured that the policy applied for will not be issued; or
(e) the date Mutual mails notice of termination of this Agreement to the Proposed Insured.

3 The temporary insurance provided by this Agreement is subject to the provisions of the policy form applied for and accepted for issuance in this state, and has the same benefits as such policy form and series; **but in no event shall benefits payable to a Proposed Insured under this Agreement exceed the Maximum Benefit payable under the policy, or $50,000, whichever amount is less.**

4 **In no event will benefits be paid for the same covered Critical Illness Insured Condition under both this Agreement and any policy issued from the application.**

5 If any of the answers to the questions on the application given by a Proposed Insured are incorrect or misleading, then this Agreement is void as to that Proposed Insured and never went into effect.

This Agreement does not limit Mutual in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of a Proposed Insured is rejected by Mutual, the amount paid with the application for that Proposed Insured will be refunded regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I/We, the undersigned, understand that the temporary insurance provided under this Agreement for each Proposed Insured will be the Maximum Benefit amount under the policy applied for, or $50,000, whichever amount is less.

I/We, the undersigned Proposed Insured(s), have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed this _____ day of _____ (Month), _____ (Year) at _____ City _____ State _____ ZIP Code

_____ **X** _____ _____
Producer's Signature — Signature of Proposed Insured — Please print name

_____ **X** _____ _____
Producer's Signature — Signature of Spouse (If a Proposed Insured) — Please print name

Company Copy

The HIV Virus

Many people who are infected with the HIV virus have not developed any symptoms, while others have had relatively minor illnesses. The most serious form of illness caused by the virus is Acquired Immune Deficiency Syndrome (AIDS), which involves loss of the body's natural immune defenses against disease.

AIDS is a life-threatening disorder of the immune system. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have had sexual contact of any of these persons.

The only reliable way to tell if you are infected with HIV is to get tested. This is because many people with HIV do not experience symptoms for years after the initial infection or have symptoms that are very similar to symptoms of other illnesses. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

The AIDS Antibody Test

HIV antibody tests are the most appropriate test for routine diagnosis of HIV among adults. Antibody tests are inexpensive and very accurate. The ELISA antibody test (enzyme-linked immunoabsorbent) also known as EIA (enzyme immunoassay) was the first HIV test to be widely used.

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or your own health care provider.

Counseling Resources List

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to the Insurer. Therefore, the Insurer makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Insurer makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE – U.S. PUBLIC HEALTH SERVICE
1-800-342-AIDS

SPANISH AIDS HOTLINE
1-800-222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM – BAKERSFIELD
(805) 861-3631

CENTRAL VALLEY AIDS TEAM
Fresno
(209) 264-2436

AIDS PROJECT – EAST BAY
Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION
Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 864-5855

SANTA CLARA COUNTY ARIS PROJECT
CAMPBELL
(408) 370-3272

SONOMA COUNTY AIDS FOUNDATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE
So. California
1-800-922-AIDS

HEMOPHILIA FOUNDATION OF SO. CA
Social Services – So. California
Hemophilia AIDS Information
(818) 793-6192 (714) 740-2222

CALIFORNIA DEPARTMENT OF HEALTH SERVICES – Statewide Services
Office of AIDS – Sacramento
(916) 323-7415

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
Costa Mesa
(714) 646-0411

AIDS PROJECT – LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SANTA BARBARA COUNTY AIDS INFORMATION HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252

GIVE THIS COPY TO THE APPLICANT

Consent for Initial Bank Withdrawal

When my application(s) is/are approved, I authorize Mutual of Omaha Insurance Company and/or its affiliates* to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including delays in issuance or possible underwriting adjustments.

*United of Omaha Life Insurance Company • United World Life Insurance Company • In New York, Companion Life Insurance Company

Policy Number

Signature of Payor

Date

The Importance of An Accurate Health History

Keeping up to Date...

It's been said that one constant in the world...is change. That's certainly true in the insurance industry, where we've seen significant changes in the past few years. The Mutual of Omaha companies have responded by working hard to meet the needs and demands of our policyowners through development of new comprehensive and competitive products.

With the development of new products, we've seen subsequent adaptations and revisions of underwriting guidelines and risk evaluations reflecting these changes. As a result, it's very important that you be prepared to help us compile a complete and accurate personal health profile.

Our Best Source of Information

We feel that our best source for a precise picture of your health is you. Likewise, we feel that the best source for health appraisal questions is the person who actually reviews your application.

What is Client Interview?

The Client Interview is based on a telephone dialogue between you and an underwriting representative. This customer friendly information gathering process has a goal that no question is asked more than once and that all questions are pertinent. Requirements that were once ordered as a matter of course are now ordered based on the merits of the individual case.

The Basis for a Contract

A Client Interview phone call normally is completed in approximately 15 minutes. It's important to note that the telephone dialogue between you and our underwriting representative will be tape recorded and relied upon as part of our risk analysis. As a result, it's important that you be as prepared and accurate as possible.

- As part of the interview, you may be asked questions regarding:
  - Primary Care Physician Name, address and phone number as well as the date and reason for your last visit
  - Secondary or referral physicians
  - Medication names and dosages
- A partial list of impairments that you may be asked about include treatment for:
  - Heart disease
  - High blood pressure
  - Cancer or tumor
  - Respiratory disease
  - Stomach or liver disorder
  - Mental or nervous disorders
  - Diabetes
  - Use of tobacco products

Additional Requirements

Based on the data collected from your interview and other outside sources, additional requirements may need to be ordered. The most common of these requirements are:

- Attending Physicians Statement (APS): Medical records from your physician
- Blood/Urine Profile: A blood sample (less than 2 ounces) and urine specimen, at no cost to you by contractors selected by the Mutual of Omaha companies for their exemplary reputation for safety, efficiency, professionalism and dependability

Your specimen will be analyzed by a certified technologist in a nationally licensed laboratory for the following:

- Cholesterol and related blood lipids
- Diabetes
- Liver or kidney disorders
- Infection by the AIDS virus
- The presence of medications, drugs, nicotine or their metabolites

Confidential Information

At the Mutual of Omaha companies, we take responsibility for safeguarding the privacy of information pertaining to our applicants and policyowners very seriously. The contents of your Client Interview phone call, as well as the results of any medical testing, will not be released without the applicant's written authorization, and are used solely to determine insurance eligibility. Law protects this confidentiality.

To Help You Help Us

To assist with the completion of the Client Interview process, we're providing the space below to record pertinent information:

Primary Care Physician:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Date/Reason Last Seen: _____

Referral Physician:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Date/Reason Last Seen: _____

Second Referral Physician:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Date/Reason Last Seen: _____

Current Medications:

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Completing Your Client Interview

Call: **1-800-775-3000**

Hours: **8:00 a.m. - 7:00 p.m.** *CST* **Monday - Thursday**

8:00 a.m. - 5:00 p.m. *CST* **Friday**

Plan Information

Plan Applied For: _____

Face/Benefit Amount: _____