Illinois — Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or are changing brokerage firms
_____	☐☐☐☐☐☐☐☐☐	☐☐☐%	☐☐
_____	☐☐☐☐☐☐☐☐☐	☐☐☐%	☐☐

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – United World Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date
- Tobacco rates do not apply during open enrollment or guaranteed issue situations

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Household Premium Discount Information
- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions
- If either Applicant A or B answered "YES" to question BOTH questions 7(a) and 7(b) or question 8 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section I: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section K: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Calculate Your Premium form**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with IL Civil Union Law Notice and Notice of Information Practices**

☐ **Complete the Medicare supplement Checklist and leave a copy with the applicant.**

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Note: An interviewer may call to verify/confirm the information provided on the application.
This form is required if splitting commissions.

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:
(Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

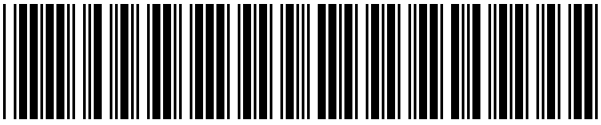
ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE



Evidence of eligibility is required for the following situations.

Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility:

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)
g. Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

M27788_0815

United World Life Insurance Company

A Mutual *of* Omaha Company

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan

Applicant A _____

Applicant B _____

Before you begin: *Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.*

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 51502		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$128.52		
#3	**Household Premium Discount** Please refer to the application for state specific household discount premium rules. **If the rules apply,** multiply the amount from Step #2 by .93. **If the rules do not apply,** enter the amount from Step #2.	$128.52 x .93 = $119.52 In this example, the person qualifies for the household premium discount.		
#4	**Rate Adjustment** *If you're in your open enrollment or guaranteed issue period, skip to Step #5.* **Locate your height, then weight on the next page.** • If your weight is in the Standard column, enter the amount from Step #3 • If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 1.20 if in Class II column	$119.52 x 1.20 = $143.42 Person's weight is in the Class II column.		
#5	**Payment Options** Your monthly payment is your last premium entered (Step #3 or #4). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$143.42 monthly payment $430.26 quarterly payment $860.52 semiannual payment $1,721.04 annual payment		

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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	‹ 54	54 – 60	61 – 110	111 – 128	129 – 145	146 +
4' 3''	‹ 56	56 – 62	63 – 114	115 – 133	134 – 151	152 +
4' 4''	‹ 58	58 – 65	66 – 119	120 – 138	139 – 157	158 +
4' 5''	‹ 60	60 – 67	68 – 123	124 – 143	144 – 163	164 +
4' 6''	‹ 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7''	‹ 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8''	‹ 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9''	‹ 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4' 10''	‹ 72	72 – 81	82 – 148	149 – 172	173 – 196	197 +
4' 11''	‹ 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0''	‹ 77	77 – 87	88 – 158	159 – 184	185 – 209	210 +
5' 1''	‹ 80	80 – 89	90 – 164	165 – 190	191 – 216	217 +
5' 2''	‹ 83	83 – 92	93 – 169	170 – 196	197 – 224	225 +
5' 3''	‹ 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5' 4''	‹ 88	88 – 99	100 – 180	181 – 209	210 – 238	239 +
5' 5''	‹ 91	91 – 102	103 – 186	187 – 216	217 – 246	247 +
5' 6''	‹ 93	93 – 105	106 – 192	193 – 223	224 – 254	255 +
5' 7''	‹ 96	96 – 108	109 – 197	198 – 229	230 – 261	262 +
5' 8''	‹ 99	99 – 111	112 – 203	204 – 236	237 – 269	270 +
5' 9''	‹ 102	102 – 115	116 – 209	210 – 243	244 – 277	278 +
5' 10''	‹ 105	105 – 118	119 – 216	217 – 250	251 – 285	286 +
5' 11''	‹ 108	108 – 121	122 – 222	223 – 258	259 – 293	294 +
6' 0''	‹ 111	111 – 125	126 – 228	229 – 265	266 – 302	303 +
6' 1''	‹ 114	114 – 128	129 – 234	235 – 272	273 – 310	311 +
6' 2''	‹ 117	117 – 132	133 – 241	242 – 280	281 – 319	320 +
6' 3''	‹ 121	121 – 136	137 – 248	249 – 288	289 – 328	329 +
6' 4''	‹ 124	124 – 139	140 – 254	255 – 295	296 – 336	337 +
6' 5''	‹ 127	127 – 143	144 – 261	262 – 303	304 – 345	346 +
6' 6''	‹ 130	130 – 147	148 – 268	269 – 311	312 – 354	355 +
6' 7''	‹ 134	134 – 150	151 – 275	276 – 319	320 – 363	364 +
6' 8''	‹ 137	137 – 154	155 – 282	283 – 327	328 – 373	374 +
6' 9''	‹ 140	140 – 158	159 – 289	290 – 335	336 – 382	383 +
6' 10''	‹ 144	144 – 162	163 – 296	297 – 344	345 – 392	393 +
6' 11''	‹ 147	147 – 166	167 – 303	304 – 352	353 – 401	402 +
7' 0''	‹ 151	151 – 170	171 – 311	312 – 361	362 – 411	412 +
7' 1''	‹ 155	155 – 174	175 – 318	319 – 369	370 – 421	422 +
7' 2''	‹ 158	158 – 178	179 – 326	327 – 378	379 – 431	432 +
7' 3''	‹ 162	162 – 183	184 – 333	334 – 387	388 – 441	442 +
7' 4''	‹ 166	166 – 187	188 – 341	342 – 396	397 – 451	452 +

Medicare supplement insurance is underwritten by
United World Life Insurance Company
A Mutual *of* Omaha Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
mutualofomaha.com

W104900

W104900

Agent Writing # _____ DNIS _____ Auth # _____

Group # (if applicable) _____ Keyline _____

United World Life Insurance Company

A Mutual *of* Omaha Company

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

A. Plan Information (to be completed by Producer)

	Applicant A	Applicant B
Plan (select one)	☐ Plan A ☐ Plan F ☐ Plan F - High Deductible ☐ Plan G ☐ Plan N	☐ Plan A ☐ Plan F ☐ Plan F - High Deductible ☐ Plan G ☐ Plan N
Requested Effective Date	___ / ___ / ____	___ / ___ / ____
Deliver Policy to	Applicant A ☐ Producer ☐	Applicant B ☐ Producer ☐

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address (if different from Applicant A's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP _____	State ZIP _____
Home Phone ___ – ___ – ____ (area code)	Home Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ___ / ___ / ____ mo day yr	Current Age _____ Date of Birth ___ / ___ / ____ mo day yr
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___

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B. Applicant Information (Continued)

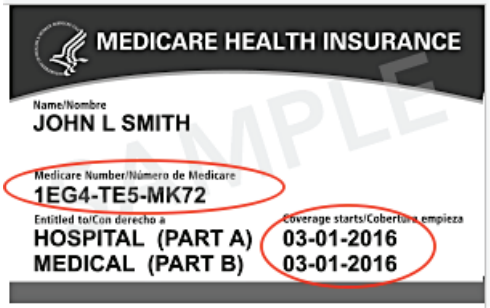
Applicant A	Applicant B
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months?..... ☐ Y ☐ N	Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months?..... ☐ Y ☐ N

Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United of Omaha Life Insurance Company.

Receive statement online? ..... ☐ Y ☐ N	Receive statement online? ..... ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date ___/___/_____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/_____	Medicare Part A Effective Date ___/___/_____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/_____
Medicare Part B Effective Date ___/___/_____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/_____	Medicare Part B Effective Date ___/___/_____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/_____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant A**	**Applicant B**
1. Does a member of your household: (a) with whom you have continuously resided for the last 12 months; or (b) to whom you are either married or in a civil union partnership either have an existing Medicare Supplement plan with, or are applying for coverage with United World Life Insurance Company, United of Omaha Life Insurance Company, Omaha Insurance Company, or Mutual of Omaha Insurance Company?.....	☐ Y ☐ N	☐ Y ☐ N

2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

Name (First/Middle/Last)
Policy Number
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:	**Applicant A**	**Applicant B**
3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N
Please answer questions regarding another Medicare supplement or Select plan:		
4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Indicate planned termination or disenrollment date.....	Applicant A ☐☐/☐☐/☐☐☐☐	
	Applicant B ☐☐/☐☐/☐☐☐☐	
(c) With what company, and what plan do you have?		

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):	**Applicant A**	**Applicant B**
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START ☐☐/☐☐/☐☐☐☐	
	END ☐☐/☐☐/☐☐☐☐	
	Applicant B START ☐☐/☐☐/☐☐☐☐	
	END ☐☐/☐☐/☐☐☐☐	
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(c) Planned date of termination/disenrollment?.....	Applicant A ☐☐/☐☐/☐☐☐☐	
	Applicant B ☐☐/☐☐/☐☐☐☐	
(d) Was this your first time in this type of Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(f) Is your former Medicare supplement or Medicare Select policy certificate still available?	☐ Y ☐ N	☐ Y ☐ N

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(g) Please indicate reason for termination/disenrollment:	Check box(s) below if applicable Applicant A	Applicant B
■ Your Medicare Advantage plan is leaving the Medicare program.....	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan.....	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....	☐	☐

■ Other: _____
Applicant A

_____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
6. Have you had coverage under any other health insurance within the past 63 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank..... Applicant A START __/__/____

END __/__/____

Applicant B START __/__/____

END __/__/____

(b) Planned date of termination/disenrollment?..... Applicant A __/__/____

Applicant B __/__/____

(c) Have you disenrolled from your current coverage voluntarily?.....	☐ Y ☐ N	☐ Y ☐ N

(d) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

(e) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you applying during an open enrollment period?		
(a) Did you turn age 65 in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Did you enroll in Medicare Part B in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A __/__/____

Applicant B __/__/____

8. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N

STOP **IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.**

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If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS G & H and GO TO SECTION I.

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information

For all plans, answer questions 9-20. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
11. Have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
12. At any time have you been medically diagnosed with, treated or tested for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a physician or an appropriately licensed clinical professional acting within the scope of his/her license?	☐ Y ☐ N	☐ Y ☐ N
13. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Y ☐ N	☐ Y ☐ N
14. Do you have Osteoporosis, and as a result, experienced a fracture?	☐ Y ☐ N	☐ Y ☐ N
15. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	☐ Y ☐ N	☐ Y ☐ N
16. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N

Part B: Medical Questions: (If "YES" is answered to any of the following questions 17-20 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
17. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement?	☐ Y ☐ N	☐ Y ☐ N
18. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)?	☐ Y ☐ N	☐ Y ☐ N
B. Had any changes in your medications within the past two years?	☐ Y ☐ N	☐ Y ☐ N
19. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
20. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N

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

H. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
21. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	☐ Y ☐ N	☐ Y ☐ N

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

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I. Agreement and Authorization

IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED WORLD LIFE INSURANCE COMPANY

- I authorize any physician, 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, the group of companies which presently includes Omaha Insurance Company, Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United World Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United World Life Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that United World Life Insurance Company has taken action in reliance on the authorization or the law allows United World Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are 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.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- 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.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United World Life Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

✍ Dated at _____, on ☐☐/☐☐/☐☐☐☐ _____

City State Month Day Year Applicant A's Signature

✍ Dated at _____, on ☐☐/☐☐/☐☐☐☐ _____

City State Month Day Year Applicant B's Signature (if applying)

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J. Producer Comments (please attach a separate sheet if needed)

K. To be Completed by Producer

22. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).
(a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant(s)..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant(s)..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

WA5981-11

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ **Initial premium amount** (based on age at application date).....	$ ☐☐☐☐☐.☐☐	$ ☐☐☐☐☐.☐☐
1. Paper Check (submit signed check with application).....	☐	☐
2. Automated Bank Account Withdrawal.....	☐	☐
Ongoing Premium Payments (Select option #1 or #2)		
1. I want my payments automatically withdrawn from my bank account every month on **(Circle date)**.....	☐ 1st **or** ☐ 15th	☐ 1st **or** ☐ 15th
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing).....	**every_____months** Insert 3, 6, or 12	**every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is placed inforce.**

Part II. Payor Information

	Applicant A	Applicant B
1. **Account Owner Name,** if different than applicant's.....	_____	_____
2. If premium is **NOT** paid by Proposed Insured/Insured **(includes spouse or joint-married account),** indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.		
Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	☐	☐
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A
Account Type (check one): ☐ Checking ☐ Savings

_____
Name of Financial Institution

☐☐☐☐☐☐☐☐☐
Routing Number (9 digits on lower left side of check)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Account Number (Do NOT use Debit/Credit Card numbers)

_____
Name as Shown on Account

Applicant B ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

_____
Name of Financial Institution

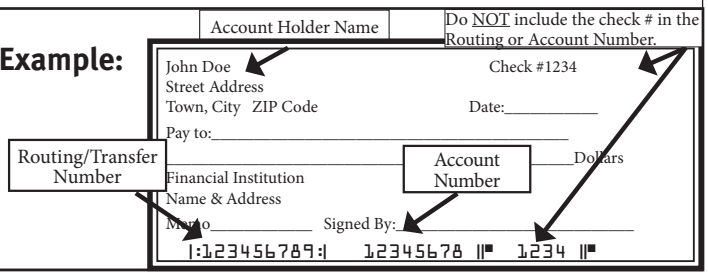
☐☐☐☐☐☐☐☐☐
Routing Number (9 digits on lower left side of check)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Account Number (Do NOT use Debit/Credit Card numbers)

_____
Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



W27785_0314

Part III. Account Information (continued)

I authorize United World Life Insurance Company ("United World") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United World any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, United World may require written confirmation from me within 14 days after my verbal notice.

Applicant A	**Applicant B**
✍ _____	✍ _____
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
_____	_____
Date	Date

W27785_0314

United World Life Insurance Company

A Mutual *of* Omaha Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

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

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

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

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

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

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.
2. Section 363(7)(b) of the Illinois Insurance Code 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 or certificate for similar benefits to the extent such time was spent under the original policy or certificate.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✍ _____ _____

Signature of Agent, Broker or Other Representative* **Date**

United World Life Insurance Company, 3316 Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales

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United World Life Insurance Company
Medicare Supplement Checklist—ILLINOIS

Please complete the following fields and the "Existing Coverage" column with the applicant's existing coverage information.

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient Semi-private room and board, general nursing, and miscellaneous services and supplies	First 60 days	All but $1.364.00		Plan A – Nothing Plans F, High Deductible F*, G, N – $1.364.00 (Part A Deductible)	Plan A – $1.364.00 (Part A Deductible) Plans F, High Deductible F* ,G, N – Nothing
	61st through 90th day	All but $341.00 a day		Plans A, F, High Deductible F,* G, N - $341.00 a day	Plans A, F, High Deductible F*, G, N - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $682.00 a day		Plans A, F, High Deductible F*, G, N - $682.00 a day	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
	Beyond 150 days	Nothing		Plans A, F, High Deductible F,* G, N - 100% of Medicare eligible expenses	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
Skilled Nursing Home Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	100% of approved amounts		Plans A, F, High Deductible F*, G, - Nothing	Plans A, F, High Deductible F*, G, - Nothing
	21st through 100th days	All but $170.50 a day		Plan A – Nothing Plans F, High Deductible F*, G, N– Up to $170.50 a day	Plan A – Up to $170.50 a day Plans F, High Deductible F* ,G, N – Nothing
	101st day and after	Nothing		Plans A, F, High Deductible F*, G, N - Nothing	Plans A, F, High Deductible F*, G, N - All costs
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	First $185.00	Nothing		Plans A, G, N – Nothing Plan F, High Deductible F*– $185.00 (Part B Deductible)	Plans A, G, N – $185.00 (Part B Deductible) Plan F, High Deductible F *– Nothing
	Remainder of Medicare approved amounts	Generally 80%		Plans A, F, High Deductible F*, G, - Generally 20% Plan N - Balance, other than copayment	Plans A, F, High Deductible F*, G, - Nothing Plan N - Copayment
	Part B excess charges (above Medicare approved amounts)	Nothing		Plans A, N – Nothing Plan F, High Deductible F*, G– 100%	Plans A, N – 100% Plan F, High Deductible F *, G– Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

*After you pay $2,300 (High F deductible)

Date_____ Signature of Applicant_____

Signature of Agent/Insurance Producer _____

UNITED WORLD LIFE INSURANCE COMPANY
Medicare Supplement Checklist—ILLINOIS

Please complete the following fields and the "Existing Coverage" column with the applicant's existing coverage information.

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient Semi-private room and board, general nursing, and miscellaneous services and supplies	First 60 days	All but $1.364.00		Plan A – Nothing Plans F, High Deductible F*, G, N – $1.364.00 (Part A Deductible)	Plan A – $1.364.00 (Part A Deductible) Plans F, High Deductible F* ,G, N – Nothing
	61st through 90th day	All but $341.00 a day		Plans A, F, High Deductible F,* G, N - $341.00 a day	Plans A, F, High Deductible F*, G, N - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $682.00 a day		Plans A, F, High Deductible F*, G, N - $682.00 a day	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
	Beyond 150 days	Nothing		Plans A, F, High Deductible F,* G, N - 100% of Medicare eligible expenses	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
Skilled Nursing Home Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	100% of approved amounts		Plans A, F, High Deductible F*, G, - Nothing	Plans A, F, High Deductible F*, G, - Nothing
	21st through 100th days	All but $170.50 a day		Plan A – Nothing Plans F, High Deductible F*, G, N– Up to $170.50 a day	Plan A – Up to $170.50 a day Plans F, High Deductible F* ,G, N – Nothing
	101st day and after	Nothing		Plans A, F, High Deductible F*, G, N - Nothing	Plans A, F, High Deductible F*, G, N - All costs
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	First $185.00	Nothing		Plans A, G, N – Nothing Plan F, High Deductible F*– $185.00 (Part B Deductible)	Plans A, G, N – $185.00 (Part B Deductible) Plan F, High Deductible F *– Nothing
	Remainder of Medicare approved amounts	Generally 80%		Plans A, F, High Deductible F*, G, - Generally 20% Plan N - Balance, other than copayment	Plans A, F, High Deductible F*, G, - Nothing Plan N - Copayment
	Part B excess charges (above Medicare approved amounts)	Nothing		Plans A, N – Nothing Plan F, High Deductible F*, G– 100%	Plans A, N – 100% Plan F, High Deductible F *, G– Nothing

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*After you pay $2,300 (High F deductible)

Date_____ Signature of Applicant_____

Signature of Agent/Insurance Producer _____

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice
If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Medicare Supplement Checklist

Premium Receipt / Notice of Information Practices

United World Life Insurance Company
Medicare Supplement Checklist—ILLINOIS

Please complete the following fields and the "Existing Coverage" column with the applicant's existing coverage information.

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient Semi-private room and board, general nursing, and miscellaneous services and supplies	First 60 days	All but $1.364.00		Plan A – Nothing Plans F, High Deductible F*, G, N – $1.364.00 (Part A Deductible)	Plan A – $1.364.00 (Part A Deductible) Plans F, High Deductible F* ,G, N – Nothing
	61st through 90th day	All but $341.00 a day		Plans A, F, High Deductible F,* G, N - $341.00 a day	Plans A, F, High Deductible F*, G, N - Nothing for covered expenses
	91st to 150th day (lifetime reserve)	All but $682.00 a day		Plans A, F, High Deductible F*, G, N - $682.00 a day	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
	Beyond 150 days	Nothing		Plans A, F, High Deductible F,* G, N - 100% of Medicare eligible expenses	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
Skilled Nursing Home Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	100% of approved amounts		Plans A, F, High Deductible F*, G, - Nothing	Plans A, F, High Deductible F*, G, - Nothing
	21st through 100th days	All but $170.50 a day		Plan A – Nothing Plans F, High Deductible F*, G, N– Up to $170.50 a day	Plan A – Up to $170.50 a day Plans F, High Deductible F* ,G, N – Nothing
	101st day and after	Nothing		Plans A, F, High Deductible F*, G, N - Nothing	Plans A, F, High Deductible F*, G, N - All costs
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic, tests, durable medical equipment	First $185.00	Nothing		Plans A, G, N – Nothing Plan F, High Deductible F*– $185.00 (Part B Deductible)	Plans A, G, N – $185.00 (Part B Deductible) Plan F, High Deductible F *– Nothing
	Remainder of Medicare approved amounts	Generally 80%		Plans A, F, High Deductible F*, G, - Generally 20% Plan N - Balance, other than copayment	Plans A, F, High Deductible F*, G, - Nothing Plan N - Copayment
	Part B excess charges (above Medicare approved amounts)	Nothing		Plans A, N – Nothing Plan F, High Deductible F*, G– 100%	Plans A, N – 100% Plan F, High Deductible F *, G– Nothing

The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

*After you pay $2,300 (High F deductible)

Date_____ Signature of Applicant_____

Signature of Agent/Insurance Producer _____

UNITED WORLD LIFE INSURANCE COMPANY
Medicare Supplement Checklist—ILLINOIS

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Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Service	Benefit	Medicare Pays	Existing Coverage	Supplement Pays	You Pay
Hospital Inpatient Semi-private room and board, general nursing, and miscellaneous services and supplies	First 60 days	All but $1.364.00		Plan A – Nothing Plans F, High Deductible F*, G, N – $1.364.00 (Part A Deductible)	Plan A – $1.364.00 (Part A Deductible) Plans F, High Deductible F* ,G, N – Nothing
	61st through 90th day	All but $341.00 a day		Plans A, F, High Deductible F,* G, N - $341.00 a day	Plans A, F, High Deductible F*, G, N - Nothing for covered expenses
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	Beyond 150 days	Nothing		Plans A, F, High Deductible F,* G, N - 100% of Medicare eligible expenses	Plans A, F, High Deductible F,* G, N - Nothing for covered expenses
Skilled Nursing Home Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	100% of approved amounts		Plans A, F, High Deductible F*, G, - Nothing	Plans A, F, High Deductible F*, G, - Nothing
	21st through 100th days	All but $170.50 a day		Plan A – Nothing Plans F, High Deductible F*, G, N– Up to $170.50 a day	Plan A – Up to $170.50 a day Plans F, High Deductible F* ,G, N – Nothing
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The policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

*After you pay $2,300 (High F deductible)

Date_____ Signature of Applicant_____

Signature of Agent/Insurance Producer _____

United World Life Insurance Company

A Mutual *of* Omaha Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

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

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

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

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

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

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

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.
2. Section 363(7)(b) of the Illinois Insurance Code 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 or certificate for similar benefits to the extent such time was spent under the original policy or certificate.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

✍ _____ _____

Signature of Agent, Broker or Other Representative* **Date**

United World Life Insurance Company, 3316 Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales

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United World Life Insurance Company

A Mutual *of* Omaha Company

Premium Receipt

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

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

Applicant A

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

Applicant B

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, United World Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.

Illinois Civil Union Law Notice

Signed by Governor Quinn on January 31, 2011, the Religious Freedom Protection and Civil Union Act (Public Act 96-1513, the "Civil Union Law") allowed both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. A civil union is a legal relationship granted to unmarried adult partners by the State of Illinois. The Civil Union Law ensures that civil unions and marriage are treated identically under Illinois law. For purposes of Illinois law, the term "spouse" (and other terms that denote the spousal relationship) now includes a party to a civil union.

This notice is to inform you that in compliance with the Act, effective June 1, 2011, under all Mutual of Omaha Insurance Company or its affiliated companies insurance policies and riders covering Illinois residents, any benefit, coverage or right, governed by Illinois state law, provided to a person considered a spouse by marriage will also be provided to a party to a civil union and any benefit, coverage or right, governed by Illinois state law, provided to a child of a marriage will also be provided to a child of a civil union.

Federal law may impact how eligibility and benefits for certain insurance products are treated. For example, federal tax laws that afford favorable income-deferral options to an opposite-sex spouse under the Internal Revenue Code do not currently extend such rights to a same-sex spouse (e.g., the Federal Defense of Marriage Act).

More information of the act or how it affects insurance coverage is available by contacting the company.

Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED WORLD LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, 3316 FARNAM STREET, OMAHA, NE 68175.

Provide the completed premium receipt, if applicable, and notices to the applicant.

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