



Application Submission Checklist To United World For Medicare Supplement Coverage – MISSOURI

THIS APPLICATION MUST BE USED TO WRITE UNITED WORLD MEDICARE SUPPLEMENT PRODUCTS

- Application**
 1. Complete “Plan Information” Box
 2. Refer to the Outline of Coverage for policy forms.
 3. Answer all questions in full.
 4. Sign and Date in all places indicated.
 5. Be sure to leave all applicable forms with the proposed insured.
 6. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
 - The full modal premium is collected at the time of application.
 - Calculate the premium based on age at time of application.
 - Tobacco rates do not apply during Open Enrollment or Guarantee Issue situations.
- Provide Client with Buyer’s Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- Complete Bank Service Plan (BSP) Authorization (if applicable)**
- Provide Client with Official Receipt signed by agent**
- When Replacing a Product With a United World or Mutual of Omaha Product, Please Complete the Authorization To Disclose Personal Information W24903**
- Complete Replacement Notice W24680_0605 and leave a copy with the applicant (if applicable)**
- Provide Client with Medicare Select Policy Disclosure Agreement W24573_0605**

**Please provide additional information and comments
in the space provided on the application.**

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

BROKERAGE ONLY – Please list your “commission code” in the box on the first page of the application. This will help avoid delay in commission payment.

There are two parts to this application: One part is the general application. The other part includes necessary administrative forms that you will need at time of sale.

1. Application

Agent Completes in Full: (please print)

“Plan Information” Box

- Policy Form
- Riders (MN & WI only)
- Requested Effective Date
- Premium Collected (Amount)
- Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)
- Renewal Premium (Amount)
- Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Bank Service Plan)

*Direct Monthly billing not available

Part I “General Information”–

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

Part II “Existing Coverage Information”–

- Medicare card number (Health Insurance Claim Number) is correctly indicated for applicants already covered by Medicare. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent **must** provide this number by calling 1-877-617-5587 once it is received.
- If the applicant is not covered by Medicare, indicate “Eligibility Date” and “Date of Enrollment.”
- List all individual and group health policies held by the applicant in the appropriate section of the application.
- If the applicant is replacing current coverage with this policy, indicate the following information.
 - Name of Company
 - Issue Date
 - Policy/Certificate Number
 - Termination/Disenrollment Date
 - Plan
 - Kind of Policy

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

2. Administrative Forms

Producer Information

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

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

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

Receipt

- Detach and leave with applicant.

Authorization To Disclose Personal Information

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

Replacement Notice – complete if applicable

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

State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.



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

Application To United World Life Insurance Company For Medicare Supplement Coverage

PART I. GENERAL INFORMATION

- Print Name _____ Home Phone No. (_____) _____
 (Title) (First) (Middle) (Last) (Area Code)
- Residence Address _____
 (No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Mailing Address _____
 (No. and Street and Apt. No.) (City) (State) (ZIP Code)
- Birth Date _____ Age _____ Sex: M F Height: _____ Ft. _____ In. Weight _____ Lbs.
 Mo. Day Yr. (*current age*)
- Social Security No. _____ E-mail Address: _____
- Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage? ... Yes No
- Have you used tobacco in any form in the past 12 months? Yes No

PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

To the best of your knowledge:

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

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

- If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____
 - If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
 - If yes, have you received a copy of the replacement notice? Yes No
 - Reason for termination/disenrollment? _____
 - Planned date of termination/disenrollment ____/____/____
 - Was this your first time in this type of Medicare plan? Yes No
 - Did you drop a Medicare Supplement policy to enroll in this Medicare plan? Yes No
- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No
 (a) If so, with what company and what kind of policy?

Name of Company	Kind of Policy

(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.

START ____/____/____ END ____/____/____

(c) Reason for termination/disenrollment? _____

(d) Date of termination/disenrollment ____/____/____

7. (a) Do you have another Medicare Supplement insurance policy in force? Yes No

(b) If so, with what company, and what plan do you have?

Name of Company	Policy/Certificate Number	Plan	Issue Date

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?..... Yes No

(d) If "Yes," indicate termination date. _____ **Have you received a copy of the Replacement Notice?.....** Yes No
 Mo. Day Yr.

8. Are you covered for medical assistance through the state Medicaid program? [NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.] Yes No

If yes, (a) Will Medicaid pay your premiums for this Medicare Supplement policy?..... Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?..... Yes No

9. Producers shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

(b) List policies sold in the past five (5) years which are no longer in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

PART III. HEALTH /MEDICAL QUESTIONS (COMPLETE IN FULL)

1. **If the answer is "Yes" to any of the following health questions (a)-(n), you are not eligible for coverage. (If you are applying for coverage during open enrollment or during a guaranteed issue period, do not answer questions 1 & 2 in section III.)**

- | | Yes | No |
|--|--------------------------|--------------------------|
| (a) Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Have you been diagnosed with Parkinson's Disease or Multiple or Lateral Sclerosis, osteoporosis with fractures, or kidney disease requiring dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Do you have diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Do you have diabetes that has ever required more than 50 units of insulin daily?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse; cirrhosis; mental or nervous disorder requiring psychiatric care; or have you had any amputation caused by disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure); peripheral vascular disease; congestive heart failure or enlarged heart; stroke; transient ischemic attacks (TIA), or heart rhythm disorders?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis, or have you been advised to have a joint replacement?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Have you been advised by a physician that surgery may be required within the next twelve months for cataracts?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (l) Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? | <input type="checkbox"/> | <input type="checkbox"/> |
| (m) Have you been hospital confined three or more times in the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| (n) Have you had an organ transplant or been advised by a physician to have an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |

2. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If "Yes," please list the drug and the condition. (Use page 4 of application, if more space is necessary.)

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

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

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- (a) You do not need more than one Medicare Supplement policy.
- (b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.
- (c) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- (d) If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (e) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Dated at _____, on _____, _____, _____, _____
 (City) (State) (Month) (Day) (Year) (Signature of Applicant)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

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

Producer(s) Information

Producer Name: _____ Social Security No. _____
Comm. % Share: _____ Producer Phone No. (____) _____ Commission Code: _____
Producer E-mail Address: _____ @ _____

Producer Name: _____ Social Security No. _____
Comm. % Share: _____ Producer Phone No. (____) _____ Commission Code: _____
Producer E-mail Address: _____ @ _____

Producer Name: _____ Social Security No. _____
Comm. % Share: _____ Producer Phone No. (____) _____ Commission Code: _____
Producer E-mail Address: _____ @ _____

(Note: Producers must be under the same commission code to share or split commissions.)

Producer To Complete Only If Premium Is To Be Paid With A Business Check

Is the applicant:	Yes	No
(a) unemployed?.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) employed, but not working for the business that is paying the premium?	<input type="checkbox"/>	<input type="checkbox"/>
(c) the business owner or spouse of the business owner?	<input type="checkbox"/>	<input type="checkbox"/>

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

Official Receipt

Check or Money Order Application

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

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

Received of _____

this _____ day of _____, _____ an application

for a Form _____ Policy and Riders _____

and Check or Money Order for _____ Dollars.

Should the Company decline to issue the insurance applied for, I hereby agree to return the above sum to the applicant.

Agent _____

NOTICE TO APPLICANT: Eligibility for the health and accident insurance applied for is conditional upon all of the following:

(a) payment of the full, initial premium; (b) written application; (c) satisfying the Company's underwriting standards.

If you are not eligible, no insurance or temporary or interim insurance of any kind will be effective.

Complete Receipt in full and leave with applicant at time of application.

Authorization To Disclose Personal Information To United World Life Insurance Group

MEANINGS OF TERMS

“Medical Persons and Entities” means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

“Psychotherapy Notes” means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

“Specified Companies” means:

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

AUTHORIZATION TO DISCLOSE

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to United World Life Insurance Company.

PURPOSES

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits.

POTENTIAL FOR REDISCLOSURE

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

FAILURE TO SIGN

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

EXPIRATION AND REVOCATION

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

ATTN: Individual Underwriting
United World Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that United World Life Insurance Company has taken action in reliance on the authorization or the law allows United World Life Insurance Company to contest the issuance of the policy or a claim under the policy.

COPY

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

NAMES AND SIGNATURES

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

Printed Name of Proposed Insured

Signature of Proposed Insured

Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

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

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

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

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

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

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

(Signature of Agent, Broker or Other Representative)*

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

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

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

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

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

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

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

If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

(Signature of Agent, Broker or Other Representative)*

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

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

Medicare Select Policy Disclosure Agreement

I acknowledge receipt of the following information:

1. Outline of Coverage
2. Description of the restricted network provisions including:
 - (a) network providers;
 - (b) payments for coinsurance and deductibles when providers other than network providers are utilized;
 - (c) coverage for emergency and urgently needed care and other out of service area coverage;
 - (d) limitations on referrals to restricted network providers;
 - (e) description of my rights to purchase a Medicare supplement policy of equal or lesser benefits offered in my state by United World;
 - (f) United World Life Insurance Company's Quality Assurance Program; and
 - (g) United World Life Insurance Company's Grievance Procedures.

I also understand the following:

United World does not recommend the purchase of a Medicare Select policy if I live more than 30 miles from a network hospital; unless the network hospital is the closest hospital which offers this level of service.

I have received full and fair disclosure of the information described above.

Signature of the Proposed Insured

Date