

UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

P.O. Box 3608 Omaha, Nebraska 68103-3608



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

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.
- Provide Client with Buyer’s Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- If applicable, complete the Authorization for Automatic Funds Withdraw form (ACH/BSP form M26238_0608) and return with the completed application.**
- Provide Client with Conditional Receipt signed by agent**
- Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form W24903_IN). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period.**
- Complete Replacement Notice (W24680_0605) and leave a copy with the applicant (if applicable)**

**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
 - Requested Effective Date
 - Premium Collected (Amount)
 - Initial Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
 - Renewal Premium (Amount)
 - Renewal Mode* (A=Annual, S=Semiannual, Q=Quarterly, or B=Automatic Funds Withdraw)
- *Direct Monthly billing not available

Part I “General Information”–

- The Residence address and ZIP code are indicated. Alternate address for billing as indicated (when applicable).
- The applicant’s current age at time of application.
- The applicant’s Social Security number as indicated from applicant’s Social Security Card.
- For applicants already covered by Medicare, include applicant’s Medicare number on the application as indicated from the applicant’s Medicare Health Insurance Card. 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.
- The applicant’s current Height in feet and inches and Weight in pounds.

Part II “Existing Coverage Information”–

- Please complete all questions in full.
- 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/Agent Information

- Be sure to include your Social Security number and commission code.
NOTE: This information is necessary for the underwriting process and commission payment.
- Include your telephone number, e-mail address and FAX number for contact purposes.

Authorization for Automatic Funds Withdraw by Mutual of Omaha Life Insurance Company (ACH/BSP) – If applicant chooses to pay premium by ACH/BSP, complete this form accurately and in its entirety and return with the application.

- **Option A** - Pay all premiums (1st & montly renewals) by ACH/BSP - DO NOT submit a check for payment.
- **Option B** - Pay 1st month by paper check & monthly renewals by BSP - A check for initial monthly premium **MUST** be submitted with the application
- **Option C** - Pay 1st month by ACH & pay renewals by direct bill (monthly direct billing is not offered) - DO NOT submit a check for initial premium payment.

Conditional Receipt

- Complete, sign, detach and leave with applicant.

Authorization To Disclose Personal Information (HIPAA)

- If client is **NOT** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form **IS** a requirement. Please have the applicant read the form, fill in required information, sign, date and leave a copy of the completed and signed form with applicant.
- If client **IS** applying during an Open Enrollment or Guaranteed Issue Period, completing the Authorization To Disclose Personal Information form is **NOT** a requirement.

Replacement Notice – complete if applicable

- Complete form including signature and date.
- 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

1. Print Name _____ Home Phone No. (_____) _____
(Title) (First) (Middle) (Last) (Area Code)
2. Residence Address _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
3. Mailing Address _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)
4. Birth Date _____ Age _____ Sex: M F Height: _____ Ft. _____ In. Weight _____ Lbs.
Mo Day Yr (current age)
5. Social Security No. _____ E-mail Address: _____
6. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage?.. Yes No
7. 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:

1. 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
2. Did you turn age 65 in the last 6 months?..... Yes No
3. 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
4. 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.**

5. (a) 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 _____ / _____ / _____
- (b) 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
- (c) **If yes, have you received a copy of the replacement notice?** Yes No
- (d) Reason for termination/disenrollment? _____
- (e) Planned date of termination/disenrollment _____ / _____ / _____
- (f) Was this your first time in this type of Medicare plan? Yes No
- (g) Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No
6. 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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| (e) Have you been diagnosed with or treated for Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?..... | <input type="checkbox"/> | <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"/> | <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"/> | <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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| (k) Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| (m) Have you been hospital confined three or more times in the last two years? | <input type="checkbox"/> | <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"/> | <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

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Producer(s) Information

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

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

(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/Account

Initial Payment

Is the applicant: Yes No

(a) unemployed?.....

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

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

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

Renewal Payment

Is the applicant: Yes No

(a) unemployed?.....

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

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

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

AUTHORIZATION FOR AUTOMATIC FUNDS WITHDRAW (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

- | Medicare Supplement Premium Payment Options: | YES | NO |
|--|--------------------------|--------------------------|
| a. Pay all premiums (1st month and monthly renewals) by ACH/BSP | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pay initial premium by paper check and pay monthly renewals by BSP | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pay initial premium by ACH and pay renewals by direct bill (monthly direct billing is not offered) | <input type="checkbox"/> | <input type="checkbox"/> |
- Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected below.**

List amount of initial premium payment withdrawal, if applicable \$ _____

Withdrawal date for monthly renewal payments, if applicable (circle one) 1st or 15th

- Is a business account being used to pay premiums? YES NO
- If yes, is the applicant:
- (a) Unemployed..... YES NO
 - (b) Employed, but not working for the business that is paying the premium..... YES NO
 - (c) The business owner or spouse of the business owner YES NO
- If (a), (b), or (c) are "Yes," premiums CAN be paid with a business account**

Account Type (check one): Checking Savings
 Complete information below or attach a voided check

Name of Financial Institution

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

Account Number

Name as Shown on Account

I authorize Mutual of Omaha and/or United World Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha and/or United World Life Insurance Company to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha and/or United World Life Insurance Company. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Authorized Signature as Shown on Account

Date

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR AUTOMATIC FUNDS WITHDRAW (ACH/BSP) FORM

The applicant may select one of three payment options indicated on the front side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by ACH/BSP

When choosing to pay both the initial and monthly renewals by ACH/BSP, the applicant must complete the form and submit it with the application. DO NOT submit a check for payment, however, a voided check may be submitted in lieu of completing the account information (account/routing numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)

When choosing to pay the initial premiums by ACH and renewal premiums by direct billing, the applicant must complete the form and submit it with the application. DO NOT submit a check for the initial premium payment, however, a voided check may be submitted in lieu of completing the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premiums by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments can not be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the ACH/BSP form accurately and in its entirety, making sure that all required information is correct and complete on your ACH/BSP form prior to submission. In addition, please make sure that the premium amount is filled in on the ACH/BSP form, so we can initiate a timely and accurate withdrawal from your client's bank account.

Below is an example of how to find correct Routing and Account Numbers on your clients' checks. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

The diagram shows a check form with the following fields and labels:

- Account Holder Name:** John Doe
- Street Address:** Street Address
- Town, City Zip code:** Town, City Zip code
- Check Number:** Check #1234
- Date:** Date: _____
- Pay to:** Pay to: _____
- Dollars:** _____ Dollars
- Bank Name & Address:** Bank Name & Address
- Memo:** Memo _____
- Signed By:** Signed By: _____
- Bank Routing/Transfer Number:** :123456789: (indicated by a bracket below the first part of the MICR line)
- Bank Account Number:** 12345678 (indicated by a bracket below the second part of the MICR line)
- Check Number (if shown at bottom, may be shown before or after the account #):** 1234 (indicated by a bracket below the third part of the MICR line)

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Conditional 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.

UNITED WORLD LIFE INSURANCE COMPANY

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INDIANA - Authorization To Disclose Personal Information To United World Life Insurance Company

Meanings of Terms

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

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. 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

W24903-IN

UNITED WORLD LIFE INSURANCE COMPANY

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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.

1 - Home Office Copy

2 - Applicant Copy

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 - Other (please specify) _____
- _____
- _____
- _____

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(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.

1 - Home Office Copy

2 - Applicant Copy