# A Guide for Successfully Completing the Group Insurance Evidence of Insurability Form

**United of Omaha Life Insurance Company (United of Omaha) appreciates the opportunity to provide you with valuable insurance protection for yourself and/or your loved ones. So that we can effectively determine if you qualify for group insurance (whether you are seeking new coverage or additional coverage), we rely on the information you provide on this form.**

**This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.**

**Please Note: The evidence of insurability form should only be completed if these coverages are provided by your employer through United of Omaha.**

### Submission Options

- An electronic version can be completed online at *www.mutualofomaha.com/eoi*
- Complete the attached form and mail it to United of Omaha Life Insurance Company.

### Important Tips for Paper Copy Submission

- All sections of the form are to be completed by the employee. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting to United of Omaha.

### Guidelines for Section 1: Policyholder/Employer Information

The Group ID Number for your employer will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.

### Guidelines for Section 2: Employee/Member Contact & Employment Information

Employment information is for your current employer (identified in Section 1) and your current job.

### Guidelines for Section 3: Applicant (Proposed Insured) Information

In this section, you only provide information for those applying for coverage, whether yourself (the employee), your eligible dependents, or a combination thereof. (For example, if you are only applying for insurance for yourself and your spouse, you would not provide information for any children.)

Be sure to provide weight in pounds, and height in feet and inches, for all applicants.

### Guidelines for Section 4: Requested Insurance

Indicate the type(s) of insurance you are applying for, whether life, short-term disability or long-term disability.

**The evidence of insurability form should only be completed if the coverages are provided by your employer through United of Omaha.**

### Guidelines for Section 5: Requested Life Insurance Benefit Amount

Helpful Hints for (1) Current Amount of Insurance

- If you recently enrolled for life insurance and are applying for coverage in excess of the Guarantee Issue amount, the Guarantee Issue amount is the current amount you should provide.
- If you have had life insurance for some time, and are applying to increase the amount of coverage you have, provide the current amount of coverage you have. Please contact your employer/benefits administrator to confirm current amount(s) if you are uncertain.
- If you (or a dependent) do not currently have coverage, enter 0 (zero).

Helpful Hints for (2) Additional Requested Amount

- This amount is the difference between any current amount you have and the total amount of insurance you would like to have.
- The total amount of insurance available is subject to plan maximums. Consult your employer for additional plan specific information, if needed.

For (3) Total Amount of Insurance Requested, indicate the total amount of life insurance you would like to have.

## Guidelines for Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance

- The health information provided in this section is used to underwrite your application for insurance.
- Be sure to answer all questions as honestly and accurately as possible, and provide additional information where indicated.
- For Degree of Recovery, indicate the percent of function you have recovered. (100% indicates full recovery. Any lesser percentage would be a judgment of partial recovery.)
- If you are only applying for coverage for yourself, then answer these questions for yourself only. If you are applying for coverage for any dependents, then answer these questions for anyone included on the form.

## Guidelines for Section 8: Authorization to Disclose Personal Information & Application for Insurance

Please read this section in its entirety. By signing, you are applying for insurance coverage with United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of underwriting your application.

For any applicant, if the name associated with any medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.

To be complete, the form must be signed by you, and must also be signed by your spouse if your spouse is applying for coverage.

# United of Omaha Life Insurance Company

Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175

# Group Insurance Evidence of Insurability Form

Please print clearly in blue or black ink. All required information should be completed to avoid any delays in the processing of this application. No amount of insurance for which evidence of insurability is required will be effective until approved by the underwriting company. When complete, to help ensure efficient processing and protect your information, mail the completed application to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
P.O. Box 2476
Omaha, NE 68103-2476
Fax: (402)351-2537

**Section 1: Policyholder/Employer Information** (Required fields are marked with an asterisk (*).)

| **Policyholder/Employer Name*** | **Group ID Number*** | **Subgroup Number** (IF APPLICABLE) |
|---|---|---|
| Paragon Management Services, Inc. dba Nye Health Services | G000 _ _ _ _ | |

| **Street Address*** | **City*** | **State*** | **Zip Code** |
|---|---|---|---|
| | | | |

**Section 2: Employee/Member Contact & Employment Information** (Required fields are marked with an asterisk (*).)

| **Last Name*** | **First Name*** | **MI** |
|---|---|---|
| | | |

| **Street Address*** | **E-mail Address** |
|---|---|
| | |

| **City*** | **State*** | **Zip Code*** | **Telephone*** (XXX)XXX-XXXX |
|---|---|---|---|
| | | | |

| **Full-Time Employment Date** (MM/DD/YYYY)* | **Annual Salary*** | **Job Title/Description*** | **Avg. Hours Worked/Week** |
|---|---|---|---|
| | | | |

**Section 3: Applicant (Proposed Insured) Information** (Required fields are marked with an asterisk (*).)

**Part A – Complete if the Employee/Member is Applying for Insurance**

| **Birth Date** (MM/DD/YYYY)* | **State of Birth*** | **Gender*** | **Weight*** | **Height*** | **SSN/ID Number** |
|---|---|---|---|---|---|
| | | ☐ F ☐ M | Lbs. | Ft. In. | |

**Part B – Complete if Applying for Spouse Insurance (for Life Insurance only)**

| **Last Name*** | **First Name*** | **MI** |
|---|---|---|
| | | |

| **Birth Date** (MM/DD/YYYY)* | **State of Birth*** | **Gender*** | **Weight*** | **Height*** | **SSN/ID Number** |
|---|---|---|---|---|---|
| | | ☐ F ☐ M | Lbs. | Ft. In. | |

*Note: Use of the term "spouse" on this application refers to the person to whom you are legally married; or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live.*

**Part C– Complete if Applying for Child(ren) Insurance (for Life Insurance only)**

| **Last Name*** | **First Name*** | **Gender*** | **Birth Date** (MM/DD/YYYY)* | **Weight** | **Height** |
|---|---|---|---|---|---|
| | | ☐ F ☐ M | | Lbs. | Ft. In. |
| | | ☐ F ☐ M | | Lbs. | Ft. In. |
| | | ☐ F ☐ M | | Lbs. | Ft. In. |
| | | ☐ F ☐ M | | Lbs. | Ft. In. |

*Note: If you apply for one child, you must apply for all eligible children. Attach a list of additional children with the above information if necessary.*

**Section 4: Requested Insurance**

**Select each insurance product for which you are applying:**

☐ Life ☐ Short-Term Disability (STD) ☐ Long-Term Disability (LTD)

**Section 5: Requested Life Insurance Benefit Amount** (Required fields are marked with an asterisk (*).)

| | **Employee/Member** (IF APPLICABLE) | **Spouse** (IF APPLICABLE) | Child(ren) (IF APPLICABLE) |
|---|---|---|---|
| **(1) Current Amount of Insurance** (IFANY) | | | |
| **(2) Additional Requested Amount** | | | |
| **(3) Total Amount of Insurance Requested*** (1+2) | | | |

**Section 6: Health Information for Life and/or Disability (STD or LTD) Insurance** (A response is required for each question for each applicant.)

**Part A**

1 – During the past 5 years, has any person proposed for insurance ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following (Check all that apply):

| Condition | Member | Spouse | Condition | Member | Spouse |
|---|---|---|---|---|---|
| Urinary tract or kidney? | ☐ | ☐ | Lung or respiratory disorder? | ☐ | ☐ |
| Liver or hepatitis? | ☐ | ☐ | Chronic fatigue syndrome? | ☐ | ☐ |
| Anemia or blood (except HIV)? | ☐ | ☐ | Arthritis or joints (incl. replacements)? | ☐ | ☐ |
| Skin or connective tissue? | ☐ | ☐ | Epilepsy or any nervous, mental or emotional disorder? | ☐ | ☐ |
| Chronic Epstein-Barr? | ☐ | ☐ | Breasts or reproductive organs (incl. implants, infertility, irregular cycles, pregnancy complications)? | ☐ | ☐ |
| Cancer or tumor? | ☐ | ☐ | Neurological condition (incl. Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)? | ☐ | ☐ |
| Alcohol or drug abuse? | ☐ | ☐ | Any disease of the immune system (except HIV)? | ☐ | ☐ |
| Spine, neck or back? | ☐ | ☐ | Stroke or cerebral vascular condition? | ☐ | ☐ |
| Fibromyalgia or myalgia? | ☐ | ☐ | Diabetes or glandular condition? | ☐ | ☐ |
| High blood pressure, arteries or veins? | ☐ | ☐ | Stomach, upper or lower digestive tract? | ☐ | ☐ |
| Coronary arteries of the heart? | ☐ | ☐ | | | |

| | Member | Spouse |
|---|---|---|
| 2 – During the past 5 years, has any person proposed for insurance ever been diagnosed or treated (including medication or recommendation for treatment) by a member of the medical profession (for residents of VT, by a licensed physician) for: Acquired Immune Deficiency Syndrome (AIDS); for residents of all states except CO or IN, AIDS Related Complex (ARC); or for residents of all states except CA, IN, ME, NY or VT, Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?<br>Notice for Residents of CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.<br>Notice for Residents of MN: The applicant(s) do not have to disclose an HIV (AIDS Virus) test or test to determine a blood-borne pathogen which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility; or (3) to emergency medical service personnel who were tested as a result of performing emergency medical services. | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 3 – During the past 5 years, other than for questions 1 and 2, has any person proposed for insurance:<br>▪ Been diagnosed or treated by a medical professional?<br>▪ Had surgery or been hospitalized?<br>▪ Had a medical or diagnostic examination or evaluation?<br>▪ Had or been advised to seek treatment for any illness, injury or disorder (except HIV)?<br>▪ Received medical care? | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 4 – Has any person proposed for insurance been absent from work for more than 5 consecutive working days because of illness or injury during the past five years? | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 5 – Within the past 6 months, has any person proposed for insurance been prescribed medication by a medical professional or taken any medication requiring a prescription? | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 6 – During the past 5 years, has any person proposed for insurance regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form? | ☐ Yes<br>☐ No | ☐ Yes<br>☐ No |
| 7 – If female, are you pregnant?<br>If Yes, please provide anticipated delivery date (MM/DD/YYYY): _____ | ☐ Yes<br>☐ No | NA |

**Part B –** For any questions (except question 5) in Part A answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format. Attach a separate signed and dated sheet containing additional information if necessary.

| Ques. # | Name of Applicant | Date of Occurrence | Date of Recovery | Current Status/ Degree of Recovery | Diagnosis/Condition/Treatment/ Medication/Exam Results | Attending Physician's Name, Address & Phone |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
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| | | | | | | |

**Part C –** If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable. Attach a separate signed and dated sheet containing additional information if necessary.

| Name of Applicant | Medication Name (FROM PRESCRIPTION LABEL) | Dosage/Frequency | Dates Taken (MM/DD/YYYY - MM/DD/YYYY) | Reason for Taking |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section 7: Required Fraud Warnings – Please Read** (State specific warnings apply to the residents of each specific state.)

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT, VA and WA. If you are a resident of one of these states, please refer to the attached list for the specific fraud warning for your place of residence.)

**Section 8: Authorization to Disclose Personal Information & Application for Insurance**

**Part A – Definitions of Terms Used in Section 8**

- **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 health care services.
- **MIB Group, Inc. (MIB)** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means all health information such as medical history, prescription drug records, mental and physical condition, and drug and alcohol use, and other information such as finances, occupation, general reputation, insurance claims, motor vehicle reports and criminal activity. Personal information does not include psychotherapy notes.
- **Specified Companies** means the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become a part of this group of companies (and their successors), and other persons or entities which act on behalf of said companies to provide services to them.

**Part B – Authorization to Disclose Information**

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 the underwriting company. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim. For residents of California and Vermont, this authorization excludes the release of any information relating to any previous tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by any person or entity that may possess such information.

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 federal privacy regulations. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by the underwriting company.

**Name(s) used for medical records for any proposed insured (if different than the name(s) provided on this form):**

_____

**Part C – Authorization to Receive and Disclose Information to the MIB**

I authorize the MIB to disclose Personal Information for me (the undersigned) to the Specified Companies. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information provided in this application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize the Specified Companies to disclose Personal Information for me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom any person proposed for insurance applies for life or health insurance or to whom any proposed insured may submit a claim for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date the application is signed. I may revoke this authorization at any time by providing written notice to the address provided at the beginning of this form. I understand the revocation may not take effect before the date it is received by United of Omaha Life Insurance Company.

**Part D – Application for Insurance**

I apply for insurance for the proposed insured(s) identified in Section 3 of this application who is/are eligible for insurance. Information in this form is given to obtain the insurance requested and is true and complete, and no important circumstance or information has been withheld or omitted, to the best of my knowledge and belief. I understand that all statements contained in this application for insurance are deemed representations and not warranties.

I understand that insurance for new or additional amounts of insurance in excess of any guarantee issue amount for any proposed insured does not begin until United of Omaha Life Insurance Company approves such person for such amounts, the proposed insured(s) is/are eligible for the insurance under the terms of the policy, and the appropriate premium is paid. If applicable, I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance for any proposed insured.

I understand that this application is only valid for 90 days from my signature date below. I acknowledge that incomplete information on this application may delay processing. If the Specified Companies request additional medical information to complete processing of this application, I understand that any delay in my response may make it necessary for me to submit a new application. I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued to any proposed insured.

I will retain a copy of this application with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that: (a) I understand and agree to the terms of this application; (b) this form has been completed in accordance with the instructions provided; and (c) for residents of all states except California, I have read the applicable fraud warning for my state of residence.

**SIGNATURE OF EMPLOYEE/MEMBER** (REQUIRED) _____ **DATE** ____/___/_____

**SIGNATURE OF SPOUSE** (IFAPPLYING FOR INSURANCE) _____ **DATE** ____/___/_____

**FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**

# Fraud Warnings

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

Mutual of Omaha Plaza • Omaha, NE 68175-0001
www.mutualofomaha.com/customer-service

**Please review the specific fraud warning for your place of residence prior to signing the attached form or application.**

**All Other States:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arkansas/Maine/Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kansas:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Massachusetts/Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**North Carolina/Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

## NOTICE OF INFORMATION PRACTICES

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

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

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

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

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO – ATTN: GROUP UNDERWRITING INDIVIDUAL SELECTION; MUTUAL OF OMAHA; MUTUAL OF OMAHA PLAZA; OMAHA, NE 68175.**

## MIB, INC. PRE-NOTICE

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

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information is: 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734.

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

## FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

Mutual of Omaha and its affiliated companies, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address – Attn: Group Underwriting Individual Selection; Mutual of Omaha; Mutual of Omaha Plaza; Omaha, NE 68175.

## INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha and its affiliated companies ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation.

You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it.

We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

**EMPLOYEE/MEMBER NAME*** _____

**Section 6 Addendum: Health Information for Life and/or Disability (STD or LTD) Insurance**

**Part B –** For any questions in Part A answered with "Yes", the following must be completed, as applicable. Requested dates should be in MM/DD/YYYY format.

| Ques. # | Name of Applicant | Date of Diagnosis | Date of Recovery | Current Status/ Condition | Diagnosis/Condition/Treatment/ Medication/Exam Results/Relationship | Attending Physician's Name, Address & Phone |
|---|---|---|---|---|---|---|
| | | | | | | |
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**Part C** If you responded YES to question 5 above for any proposed insured, you must complete the following, as applicable.

| Medication Name (FROM PRESCRIPTION LABEL) | Dosage/Frequency | Dates Taken (MM/DD/YYYY - MM/DD/YYYY) | Reason for Taking |
|---|---|---|---|
| | | | |
| | | | |
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