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

Mutual of Omaha appreciates the opportunity to provide you with valuable life insurance protection for yourself and/or your loved ones. So that we can effectively determine if you qualify for group life 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.

Submission Options

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

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 the 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 Mutual of Omaha.

Guidelines for Section 1: 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 Contact & Employment Information

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

To ensure any additional correspondence regarding your form occurs as quickly as possible, check the box to consent to receive future correspondence via e-mail.

Guidelines for Section 3: Applicant 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 Coverage 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, indicate the total amount of life insurance you would like to have.

Guidelines for Section 5: Health Information for Applicants

The health information provided in this section is used to underwrite your application for insurance.

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 7: Authorization to Disclose Personal Information & Application for Insurance

Please read this section in its entirety. By signing, you are applying for life insurance coverage with Mutual 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.

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.

Group Life Insurance
Evidence of Insurability Form

Underwritten by: United of Omaha Life Insurance Company Home Office: Omaha, Nebraska

Section 1: Employer Information (Please print clearly. Required fields are marked with an asterisk (*).)

Employer's Name*	Group ID Number*
	G000 __ __ __ __

Street Address	Telephone
	(__ __ __) __ __ __ - __ __ __ __

City*	State*	ZIP Code
	__ __	__ __ __ __ __ - __ __ __ __

Section 2: Employee Contact & Employment Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*	First Name*	Middle Name

Street Address*	E-mail Address

City*	State*	ZIP Code*	Telephone*
	__ __	__ __ __ __ __ - __ __ __ __	(__ __ __) __ __ __ - __ __ __ __

Full-Time Employment Date (MM/DD/YYYY)*	Job Title/Description*
__ __ / __ __ / __ __ __ __	

Consent to E-mail Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this form via e-mail.

Section 3: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee is Applying for Coverage

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	Annual Salary*
__ __ / __ __ / __ __ __ __	__ __	☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.	$

Part B – Complete if Your Eligible Dependent Spouse is Applying for Coverage

Last Name*	First Name*	MI

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*
__ __ / __ __ / __ __ __ __	__ __	☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.

Note: Use of the term "spouse" on this form refers to the person to whom you are legally married, or your domestic partner or equivalent, as recognized and allowed by federal law, or by state law in your state of residence.

Part C – Complete for Any Eligible Dependent Children Applying for Coverage

Last Name*	First Name*	Gender*	Birth Date (MM/DD/YYYY)*	Weight*	Height*
		☐ Female ☐ Male	__ __ / __ __ / __ __ __ __	_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male	__ __ / __ __ / __ __ __ __	_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male	__ __ / __ __ / __ __ __ __	_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male	__ __ / __ __ / __ __ __ __	_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male	__ __ / __ __ / __ __ __ __	_____ Pounds	____ Ft. ____ In.

Section 4: Requested Coverage Amount (Please print clearly. Required fields are marked with an asterisk (*).)

	Employee (IF APPLICABLE)	Spouse (IF APPLICABLE)	Each Child (IF APPLICABLE)
(1) Current Amount of Insurance*			
(2) Additional Requested Amount*			
(3) Total Amount (1+2)*			

Section 5: Health Information for Applicants (Please print clearly. A response is required for each health question.)

Part A – Health Questions

Health Question 1	**Response***
During the past seven years, have you or any dependent spouse or child applying for coverage ever been diagnosed by or received medical care from a medical professional for any of the following: ▪ Blood or circulatory disorder? ▪ Heart disorder? ▪ Paralysis? ▪ Mental, nervous or emotional disorder? ▪ Liver disorder? ▪ Cancer or tumor? ▪ Kidney or genitourinary disorder? ▪ Digestive disorder? ▪ Epilepsy or seizure? ▪ Lung or respiratory disorder? ▪ Diabetes? ▪ High blood pressure? ▪ Any disease of the immune system (except HIV)? ▪ Alcohol or drug abuse? ▪ Stroke?	☐ YES ☐ NO
Health Question 2	**Response***
During the past seven years, have you or any dependent spouse or child applying for coverage ever been diagnosed or treated by a member of the medical profession for having: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?	☐ YES ☐ NO
Health Question 3	**Response***
During the past five years, have you or any dependent spouse or child applying for coverage ever been prescribed medication by a medical professional or taken any medication requiring a prescription, other than for colds, flu or allergies? If yes, provide the diagnosis and the prescription below.	☐ YES ☐ NO
Health Question 4	**Response***
During the past five years, have you or any dependent spouse or child applying for coverage ever: ▪ Consulted a medical professional for any disease, disorder or condition not listed in questions 1 or 2? ▪ Been advised by member of the medical profession to have any diagnostic tests or surgical operations? ▪ Been confined to any hospital or similar institution?	☐ YES ☐ NO

Part B – If you responded YES to any questions above, you must complete the following, as applicable:

Ques. #	**Name of Applicant**	**Date of Occurrence** (MM/DD/YYYY)	**Date of Recovery** (MM/DD/YYYY)	**Condition, Injury, Diagnosis, Prescription and/or Findings of Exam**

Section 6: 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.
- **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/Kentucky/Louisiana/Maine/New Mexico/ 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.
- **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.
- **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.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil 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.
- **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 commits a fraudulent insurance act, which may be 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.
- **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.
- **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.

Section 7: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 7

- **I** or **me** means each person signing below in Part C of Section 7, except where otherwise noted.
- **MIB, Inc.** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means information about me and/or any dependent child applying for coverage, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

Part B – Authorization to Disclose Personal Information

To MIB, Inc.: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. 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 I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to MIB, Inc. I understand that the Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

Name(s) used for medical records (if different than the name(s) provided on this form): _____

_____

Part C – Application for Insurance

If I am an eligible employee applying for insurance, I apply for life insurance for me and any child identified in Section 3 of this form who is eligible for insurance. If I am an eligible spouse of the employee applying for insurance, I apply for life insurance for me. I understand that any insurance for a person applying for insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approves such person for such amounts. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I (the employee) permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until the employee's insurance certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha requests additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

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.

I will retain a copy of this form 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 form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE (REQUIRED AT ALL TIMES) _____ **DATE** __ __/__ __/__ __ __ __

SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE) _____ **DATE** __ __/__ __/__ __ __ __

Section 8: Form Submission

To help ensure efficient processing, mail the completed form to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

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