

UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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



APPLICATION for MEDICARE SUPPLEMENT INSURANCE

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United World Life Insurance Company
A Mutual of Omaha Company
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE
BENEFIT PLANS A, F, HIGH DEDUCTIBLE F, G AND N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F	F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER	Basic, including 100% Part B Coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Excess (100%)				
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)				
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$5,240; paid at 100% after limit reached	Out-of-pocket limit \$2,620; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

MONTHLY NON-TOBACCO PREMIUMS
ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885

FEMALE										MALE				
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H				
865.45					Thru 64	972.35								
98.01	139.42	39.46	101.05	82.40	65	110.12	156.64	44.34	113.53	92.58				
98.01	139.42	39.46	101.05	82.40	66	110.12	156.64	44.34	113.53	92.58				
98.01	139.42	39.46	101.05	82.40	67	110.12	156.64	44.34	113.53	92.58				
100.09	142.37	40.30	103.18	84.15	68	112.46	159.98	45.28	115.94	94.56				
102.17	145.33	41.14	105.33	85.90	69	114.80	163.29	46.22	118.34	96.51				
103.95	147.86	41.86	107.17	87.40	70	116.80	166.14	47.03	120.41	98.20				
105.73	150.40	42.57	108.99	88.89	71	118.80	168.99	47.83	122.48	99.88				
109.29	155.47	44.01	112.67	91.89	72	122.80	174.68	49.45	126.60	103.25				
113.15	160.95	45.56	116.65	95.13	73	127.13	180.84	51.19	131.07	106.89				
117.01	166.45	47.12	120.64	98.38	74	131.48	187.03	52.94	135.55	110.54				
120.88	171.95	48.67	124.62	101.63	75	135.81	193.19	54.68	140.02	114.19				
124.73	177.43	50.22	128.58	104.87	76	140.15	199.36	56.44	144.48	117.83				
128.59	182.93	51.78	132.57	108.12	77	144.50	205.55	58.19	148.97	121.49				
132.46	188.42	53.34	136.56	111.37	78	148.83	211.71	59.93	153.44	125.13				
136.31	193.89	54.89	140.53	114.61	79	153.16	217.88	61.68	157.91	128.78				
140.18	199.39	56.45	144.51	117.86	80	157.51	224.05	63.42	162.37	132.42				
143.74	204.46	57.88	148.18	120.86	81	161.51	229.75	65.04	166.51	135.80				
147.31	209.55	59.32	151.87	123.86	82	165.51	235.43	66.65	170.63	139.16				
150.87	214.60	60.75	155.54	126.85	83	169.52	241.13	68.26	174.76	142.52				
154.44	219.68	62.19	159.21	129.85	84	173.52	246.83	69.88	178.88	145.89				
157.52	224.07	63.43	162.39	132.44	85	176.99	251.77	71.27	182.46	148.81				
160.67	228.56	64.70	165.64	135.09	86	180.54	256.80	72.69	186.11	151.78				
163.88	233.12	65.99	168.95	137.79	87	184.15	261.94	74.15	189.83	154.82				
167.17	237.80	67.32	172.34	140.55	88	187.83	267.17	75.63	193.63	157.92				
170.52	242.55	68.66	175.79	143.36	89	191.58	272.52	77.14	197.51	161.08				
173.91	247.39	70.03	179.29	146.23	90	195.41	277.97	78.68	201.45	164.30				
177.40	252.35	71.43	182.89	149.15	91	199.32	283.53	80.26	205.48	167.59				
180.94	257.38	72.86	186.53	152.13	92	203.31	289.21	81.87	209.60	170.94				
184.57	262.54	74.32	190.28	155.18	93	207.37	294.98	83.50	213.78	174.35				
188.25	267.78	75.80	194.07	158.28	94	211.52	300.88	85.17	218.07	177.84				
192.02	273.15	77.32	197.96	161.45	95	215.76	306.91	86.88	222.43	181.40				
195.86	278.61	78.86	201.91	164.67	96	220.07	313.04	88.61	226.87	185.02				
199.77	284.18	80.45	205.96	167.97	97	224.47	319.30	90.39	231.42	188.73				
203.78	289.87	82.05	210.07	171.33	98	228.97	325.70	92.20	236.04	192.51				
207.86	295.66	83.70	214.28	174.76	99+	233.54	332.20	94.04	240.76	196.35				

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS
ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885

FEMALE										MALE				
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H				
994.77					Thru 64	1,117.65								
112.65	160.25	45.36	116.15	94.72	65	126.58	180.05	50.97	130.49	106.42				
112.65	160.25	45.36	116.15	94.72	66	126.58	180.05	50.97	130.49	106.42				
112.65	160.25	45.36	116.15	94.72	67	126.58	180.05	50.97	130.49	106.42				
115.05	163.64	46.32	118.60	96.72	68	129.26	183.88	52.05	133.26	108.68				
117.43	167.05	47.29	121.07	98.74	69	131.95	187.69	53.13	136.03	110.93				
119.48	169.96	48.11	123.18	100.46	70	134.25	190.96	54.05	138.40	112.87				
121.53	172.87	48.93	125.28	102.18	71	136.56	194.24	54.98	140.78	114.80				
125.62	178.70	50.58	129.50	105.62	72	141.15	200.78	56.84	145.51	118.67				
130.06	185.00	52.37	134.08	109.35	73	146.12	207.86	58.84	150.65	122.86				
134.50	191.32	54.16	138.66	113.08	74	151.13	214.97	60.85	155.80	127.06				
138.94	197.64	55.94	143.24	116.81	75	156.11	222.06	62.86	160.94	131.25				
143.37	203.94	57.73	147.80	120.54	76	161.09	229.15	64.87	166.07	135.44				
147.81	210.26	59.52	152.38	124.27	77	166.09	236.26	66.88	171.23	139.64				
152.25	216.58	61.31	156.96	128.01	78	171.07	243.34	68.89	176.36	143.83				
156.68	222.87	63.09	161.52	131.73	79	176.05	250.43	70.89	181.50	148.02				
161.13	229.19	64.88	166.10	135.47	80	181.04	257.53	72.90	186.63	152.21				
165.22	235.02	66.53	170.33	138.92	81	185.64	264.08	74.75	191.39	156.09				
169.33	240.86	68.18	174.56	142.36	82	190.24	270.61	76.61	196.13	159.95				
173.41	246.67	69.83	178.78	145.80	83	194.85	277.16	78.46	200.87	163.82				
177.52	252.50	71.48	183.00	149.25	84	199.45	283.71	80.32	205.61	167.69				
181.06	257.55	72.91	186.66	152.23	85	203.44	289.39	81.92	209.73	171.05				
184.68	262.71	74.37	190.40	155.28	86	207.51	295.17	83.56	213.92	174.47				
188.37	267.96	75.85	194.19	158.38	87	211.66	301.08	85.23	218.20	177.95				
192.15	273.33	77.37	198.09	161.55	88	215.89	307.09	86.93	222.56	181.51				
196.00	278.79	78.92	202.06	164.78	89	220.21	313.25	88.67	227.03	185.15				
199.90	284.36	80.50	206.08	168.08	90	224.61	319.50	90.44	231.55	188.85				
203.90	290.06	82.11	210.21	171.44	91	229.10	325.90	92.25	236.19	192.63				
207.98	295.84	83.75	214.41	174.86	92	233.69	332.42	94.10	240.92	196.48				
212.15	301.77	85.42	218.71	178.36	93	238.36	339.06	95.98	245.73	200.40				
216.38	307.79	87.13	223.07	181.93	94	243.13	345.84	97.90	250.65	204.42				
220.72	313.97	88.88	227.54	185.57	95	248.00	352.77	99.86	255.66	208.50				
225.13	320.24	90.65	232.08	189.28	96	252.95	359.82	101.85	260.78	212.67				
229.63	326.65	92.47	236.74	193.07	97	258.01	367.01	103.90	266.00	216.93				
234.23	333.18	94.31	241.46	196.93	98	263.18	374.36	105.98	271.31	221.27				
238.91	339.84	96.20	246.29	200.87	99+	268.43	381.84	108.09	276.74	225.69				

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY NON-TOBACCO PREMIUMS
ZIP CODES: 733, 750-753, 760-761, 774, 776-777, 782, 784, 793-794

FEMALE										MALE				
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H				
980.84					Thru 64	1,102.00								
111.08	158.01	44.73	114.52	93.39	65	124.80	177.52	50.25	128.66	104.93				
111.08	158.01	44.73	114.52	93.39	66	124.80	177.52	50.25	128.66	104.93				
111.08	158.01	44.73	114.52	93.39	67	124.80	177.52	50.25	128.66	104.93				
113.44	161.35	45.67	116.94	95.37	68	127.45	181.30	51.32	131.40	107.16				
115.79	164.71	46.62	119.37	97.36	69	130.10	185.06	52.38	134.12	109.38				
117.81	167.58	47.44	121.46	99.05	70	132.37	188.29	53.30	136.46	111.29				
119.83	170.45	48.25	123.53	100.75	71	134.65	191.52	54.21	138.81	113.20				
123.86	176.19	49.87	127.69	104.14	72	139.17	197.97	56.04	143.48	117.01				
128.24	182.41	51.64	132.21	107.82	73	144.08	204.95	58.02	148.54	121.14				
132.61	188.64	53.40	136.72	111.49	74	149.01	211.97	60.00	153.62	125.28				
137.00	194.87	55.16	141.24	115.18	75	153.92	218.95	61.98	158.69	129.41				
141.36	201.08	56.92	145.73	118.85	76	158.84	225.94	63.96	163.74	133.55				
145.74	207.31	58.68	150.25	122.53	77	163.76	232.95	65.94	168.83	137.69				
150.12	213.54	60.45	154.76	126.22	78	168.68	239.94	67.92	173.90	141.82				
154.49	219.75	62.21	159.26	129.89	79	173.58	246.93	69.90	178.96	145.95				
158.87	225.98	63.97	163.78	133.57	80	178.51	253.92	71.88	184.02	150.08				
162.91	231.73	65.60	167.94	136.97	81	183.04	260.38	73.71	188.71	153.90				
166.96	237.49	67.23	172.12	140.37	82	187.58	266.82	75.54	193.38	157.71				
170.98	243.22	68.85	176.27	143.76	83	192.12	273.28	77.36	198.06	161.52				
175.03	248.97	70.48	180.44	147.16	84	196.66	279.74	79.19	202.74	165.34				
178.53	253.95	71.89	184.05	150.09	85	200.59	285.34	80.77	206.79	168.65				
182.10	259.03	73.33	187.73	153.10	86	204.61	291.04	82.39	210.93	172.02				
185.73	264.21	74.79	191.47	156.17	87	208.70	296.86	84.04	215.14	175.46				
189.46	269.50	76.29	195.32	159.29	88	212.87	302.79	85.71	219.45	178.97				
193.26	274.89	77.82	199.23	162.47	89	217.13	308.86	87.43	223.85	182.56				
197.10	280.37	79.37	203.20	165.72	90	221.47	315.03	89.18	228.31	186.20				
201.05	286.00	80.96	207.27	169.04	91	225.90	321.34	90.96	232.88	189.93				
205.07	291.70	82.57	211.41	172.41	92	230.42	327.77	92.79	237.55	193.73				
209.18	297.55	84.22	215.65	175.87	93	235.02	334.31	94.63	242.29	197.60				
213.35	303.48	85.91	219.95	179.38	94	239.72	341.00	96.53	247.14	201.56				
217.63	309.57	87.63	224.35	182.97	95	244.52	347.83	98.47	252.08	205.58				
221.97	315.76	89.38	228.83	186.63	96	249.41	354.78	100.43	257.12	209.69				
226.41	322.07	91.17	233.42	190.37	97	254.40	361.87	102.44	262.27	213.89				
230.95	328.52	92.99	238.08	194.17	98	259.49	369.12	104.49	267.52	218.18				
235.57	335.08	94.85	242.85	198.06	99+	264.68	376.50	106.58	272.87	222.53				

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS
ZIP CODES: 733, 750-753, 760-761, 774, 776-777, 782, 784, 793-794

FEMALE										MALE				
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H				
1,127.41					Thru 64	1,266.67								
127.67	181.62	51.41	131.63	107.35	65	143.45	204.05	57.76	147.89	120.61				
127.67	181.62	51.41	131.63	107.35	66	143.45	204.05	57.76	147.89	120.61				
127.67	181.62	51.41	131.63	107.35	67	143.45	204.05	57.76	147.89	120.61				
130.39	185.46	52.50	134.42	109.62	68	146.49	208.40	58.99	151.03	123.18				
133.09	189.32	53.59	137.21	111.90	69	149.54	212.71	60.21	154.16	125.73				
135.42	192.62	54.53	139.61	113.85	70	152.15	216.42	61.26	156.86	127.92				
137.73	195.92	55.46	141.98	115.80	71	154.77	220.14	62.31	159.55	130.11				
142.37	202.52	57.32	146.77	119.70	72	159.97	227.55	64.41	164.91	134.50				
147.40	209.67	59.35	151.96	123.93	73	165.61	235.58	66.69	170.74	139.24				
152.43	216.83	61.38	157.15	128.15	74	171.28	243.64	68.96	176.57	144.00				
157.47	223.99	63.40	162.34	132.39	75	176.92	251.67	71.24	182.40	148.75				
162.49	231.13	65.42	167.50	136.61	76	182.57	259.70	73.52	188.21	153.50				
167.52	238.29	67.45	172.70	140.84	77	188.23	267.76	75.80	194.06	158.26				
172.55	245.45	69.48	177.89	145.08	78	193.88	275.79	78.07	199.88	163.01				
177.57	252.58	71.50	183.06	149.30	79	199.52	283.83	80.35	205.70	167.76				
182.61	259.74	73.53	188.25	153.53	80	205.18	291.86	82.62	211.52	172.50				
187.25	266.35	75.40	193.04	157.44	81	210.40	299.29	84.72	216.90	176.90				
191.90	272.97	77.28	197.84	161.34	82	215.61	306.69	86.82	222.28	181.27				
196.53	279.56	79.14	202.61	165.24	83	220.83	314.12	88.92	227.65	185.66				
201.19	286.17	81.01	207.40	169.15	84	226.04	321.54	91.03	233.03	190.05				
205.20	291.89	82.63	211.55	172.52	85	230.56	327.97	92.84	237.69	193.85				
209.30	297.74	84.28	215.78	175.98	86	235.18	334.53	94.70	242.44	197.73				
213.49	303.69	85.97	220.09	179.50	87	239.88	341.22	96.59	247.29	201.67				
217.77	309.77	87.69	224.50	183.09	88	244.68	348.03	98.52	252.24	205.71				
222.14	315.97	89.44	229.00	186.75	89	249.57	355.01	100.49	257.30	209.83				
226.55	322.27	91.23	233.56	190.49	90	254.56	362.10	102.50	262.43	214.03				
231.09	328.74	93.06	238.24	194.30	91	259.65	369.35	104.55	267.68	218.31				
235.71	335.28	94.91	243.00	198.18	92	264.85	376.75	106.65	273.04	222.68				
240.43	342.01	96.81	247.87	202.14	93	270.14	384.27	108.77	278.49	227.12				
245.23	348.83	98.75	252.82	206.18	94	275.54	391.96	110.96	284.07	231.67				
250.15	355.83	100.73	257.88	210.31	95	281.06	399.81	113.18	289.75	236.30				
255.14	362.94	102.73	263.03	214.52	96	286.68	407.80	115.43	295.55	241.03				
260.24	370.20	104.80	268.30	218.81	97	292.41	415.95	117.75	301.46	245.85				
265.46	377.60	106.89	273.66	223.19	98	298.27	424.28	120.11	307.49	250.78				
270.77	385.15	109.03	279.13	227.65	99+	304.23	432.76	122.50	313.64	255.79				

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY NON-TOBACCO PREMIUMS
ZIP CODES: 770-773, 775

FEMALE							MALE						
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H			
1,115.47					Thru 64	1,253.25							
126.32	179.70	50.86	130.24	106.21	65	141.93	201.89	57.15	146.32	119.33			
126.32	179.70	50.86	130.24	106.21	66	141.93	201.89	57.15	146.32	119.33			
126.32	179.70	50.86	130.24	106.21	67	141.93	201.89	57.15	146.32	119.33			
129.01	183.49	51.94	132.99	108.46	68	144.94	206.19	58.36	149.43	121.87			
131.68	187.32	53.02	135.76	110.72	69	147.96	210.46	59.57	152.53	124.39			
133.98	190.58	53.95	138.13	112.65	70	150.54	214.13	60.61	155.20	126.56			
136.27	193.85	54.87	140.48	114.58	71	153.13	217.81	61.65	157.86	128.73			
140.86	200.38	56.72	145.21	118.43	72	158.27	225.14	63.73	163.17	133.07			
145.84	207.45	58.73	150.35	122.62	73	163.85	233.09	65.98	168.93	137.77			
150.81	214.54	60.73	155.49	126.80	74	169.47	241.06	68.23	174.70	142.48			
155.80	221.62	62.73	160.62	130.98	75	175.05	249.00	70.48	180.47	147.17			
160.77	228.68	64.73	165.73	135.16	76	180.64	256.95	72.74	186.22	151.87			
165.74	235.77	66.74	170.87	139.35	77	186.24	264.93	74.99	192.00	156.59			
170.73	242.85	68.75	176.01	143.54	78	191.83	272.87	77.24	197.76	161.28			
175.69	249.91	70.75	181.12	147.72	79	197.41	280.82	79.50	203.53	165.98			
180.68	256.99	72.75	186.26	151.91	80	203.01	288.77	81.75	209.28	170.68			
185.27	263.53	74.60	190.99	155.77	81	208.17	296.12	83.82	214.61	175.03			
189.87	270.08	76.46	195.74	159.64	82	213.33	303.45	85.90	219.93	179.36			
194.45	276.60	78.30	200.47	163.49	83	218.49	310.79	87.98	225.24	183.70			
199.05	283.14	80.15	205.20	167.36	84	223.65	318.13	90.06	230.56	188.03			
203.03	288.80	81.76	209.31	170.70	85	228.12	324.50	91.86	235.17	191.80			
207.09	294.59	83.39	213.50	174.12	86	232.69	330.99	93.69	239.88	195.63			
211.23	300.47	85.06	217.76	177.60	87	237.34	337.61	95.57	244.67	199.54			
215.46	306.49	86.76	222.13	181.15	88	242.09	344.35	97.48	249.57	203.54			
219.78	312.62	88.50	226.58	184.77	89	246.93	351.25	99.43	254.57	207.61			
224.15	318.86	90.26	231.09	188.47	90	251.87	358.27	101.41	259.65	211.76			
228.65	325.26	92.07	235.72	192.24	91	256.90	365.44	103.44	264.85	216.00			
233.22	331.73	93.91	240.42	196.08	92	262.05	372.76	105.52	270.15	220.32			
237.89	338.39	95.78	245.25	200.00	93	267.28	380.20	107.62	275.54	224.72			
242.63	345.14	97.70	250.14	204.00	94	272.63	387.81	109.78	281.06	229.22			
247.50	352.06	99.66	255.15	208.09	95	278.09	395.58	111.98	286.68	233.80			
252.44	359.09	101.65	260.24	212.25	96	283.65	403.48	114.21	292.42	238.47			
257.49	366.28	103.69	265.46	216.49	97	289.32	411.54	116.50	298.27	243.25			
262.64	373.61	105.75	270.76	220.82	98	295.11	419.79	118.83	304.23	248.12			
267.90	381.07	107.87	276.18	225.24	99+	301.00	428.17	121.21	310.32	253.08			

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS
ZIP CODES: 770-773, 775

FEMALE						MALE					
Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	Attained Age	Plan A WM20H	Plan F WM24H	Plan High F WM34H	Plan G WM25H	Plan N WM35H	
1,282.15					Thru 64	1,440.52					
145.20	206.55	58.46	149.70	122.08	65	163.14	232.06	65.69	168.19	137.16	
145.20	206.55	58.46	149.70	122.08	66	163.14	232.06	65.69	168.19	137.16	
145.20	206.55	58.46	149.70	122.08	67	163.14	232.06	65.69	168.19	137.16	
148.28	210.91	59.71	152.87	124.67	68	166.60	237.00	67.08	171.76	140.08	
151.36	215.31	60.95	156.04	127.26	69	170.07	241.91	68.48	175.32	142.98	
154.00	219.05	62.01	158.77	129.48	70	173.04	246.13	69.67	178.39	145.48	
156.64	222.81	63.07	161.47	131.70	71	176.01	250.35	70.86	181.45	147.97	
161.91	230.32	65.19	166.91	136.13	72	181.92	258.78	73.25	187.55	152.96	
167.63	238.45	67.50	172.82	140.94	73	188.34	267.91	75.84	194.17	158.35	
173.35	246.59	69.81	178.72	145.74	74	194.79	277.08	78.43	200.81	163.77	
179.08	254.74	72.11	184.63	150.56	75	201.20	286.21	81.01	207.43	169.16	
184.79	262.86	74.40	190.50	155.36	76	207.63	295.35	83.61	214.04	174.57	
190.51	271.00	76.71	196.40	160.17	77	214.07	304.51	86.20	220.69	179.99	
196.24	279.14	79.02	202.30	164.99	78	220.49	313.64	88.79	227.31	185.38	
201.94	287.25	81.32	208.19	169.79	79	226.91	322.78	91.37	233.94	190.79	
207.68	295.39	83.62	214.09	174.60	80	233.35	331.92	93.96	240.55	196.18	
212.95	302.91	85.75	219.53	179.05	81	239.27	340.37	96.35	246.67	201.18	
218.24	310.44	87.88	224.99	183.49	82	245.20	348.79	98.74	252.79	206.16	
223.51	317.93	90.00	230.42	187.92	83	251.14	357.23	101.13	258.90	211.14	
228.80	325.45	92.13	235.86	192.36	84	257.07	365.67	103.52	265.01	216.13	
233.37	331.96	93.97	240.58	196.20	85	262.21	372.99	105.58	270.32	220.46	
238.03	338.60	95.85	245.40	200.14	86	267.46	380.45	107.69	275.72	224.87	
242.79	345.37	97.77	250.29	204.14	87	272.81	388.06	109.85	281.23	229.36	
247.66	352.29	99.73	255.32	208.22	88	278.26	395.80	112.04	286.86	233.95	
252.63	359.33	101.72	260.43	212.38	89	283.83	403.74	114.28	292.61	238.64	
257.65	366.50	103.75	265.62	216.63	90	289.50	411.80	116.57	298.45	243.40	
262.81	373.86	105.83	270.94	220.97	91	295.29	420.05	118.90	304.42	248.28	
268.06	381.30	107.94	276.35	225.38	92	301.21	428.46	121.29	310.52	253.24	
273.44	388.95	110.10	281.89	229.89	93	307.21	437.01	123.70	316.72	258.30	
278.89	396.71	112.30	287.52	234.48	94	313.36	445.75	126.19	323.06	263.47	
284.48	404.67	114.55	293.27	239.18	95	319.64	454.69	128.71	329.52	268.74	
290.16	412.75	116.84	299.13	243.96	96	326.03	463.77	131.28	336.11	274.11	
295.96	421.01	119.18	305.13	248.84	97	332.55	473.04	133.91	342.84	279.60	
301.89	429.43	121.56	311.22	253.82	98	339.21	482.51	136.59	349.69	285.20	
307.93	438.02	123.99	317.45	258.90	99+	345.98	492.15	139.32	356.69	290.89	

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

PREMIUM INFORMATION

We, United World, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year.

You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other adults. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to United World Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not fully cover all of your medical costs. Neither United World nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare Coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

- (a) expenses you incur while your policy is not in force, except as provided in the **EXTENSION OF BENEFITS** section;
- (b) hospital or skilled nursing facility charges incurred prior to the coverage effective date of this policy;
- (c) that portion of any expense you incur which is paid for by Medicare;
- (d) that portion of any expense that is payable under any other insurance plan, policy, or any employee benefit plan, which pays benefits on an expense-incurred basis;
- (e) non-Medicare-eligible-expenses, including, but not limited to, routine exams, take-home drugs, and eye refractions;
- (f) services for which a charge is not normally made in the absence of insurance; or
- (g) loss or expense that is payable under any other Medicare Supplement

REFUND OF PREMIUM

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid. Termination of coverage will not affect any claim originating while the policy is in force.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$0 \$335 a day \$670 a day 100% of Medicare-eligible expenses \$0	\$1,340 (Part A deductible) \$0 \$0 \$0 ** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$167.50 a day All costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$183 of Medicare Approved Amounts * Remainder of Medicare Approved Amounts	 Generally 80%	 \$0 Generally 20%	 \$183 (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts * Remainder of Medicare-approved amounts	\$0 80%	\$0 20%	\$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN A
PARTS A AND B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable Medical Equipment First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

**PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$1,340 (Part A deductible) \$335 a day \$670 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 *** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0 \$0 100%	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$183 of Medicare Approved Amounts *	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts *	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN F
PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable Medical Equipment	\$0	\$183 (Part B deductible)	\$0
First \$183 of Medicare-approved amounts*	80%	20%	\$0
Remainder of Medicare-approved amounts			

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$..... deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,240 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$2,240 DEDUCTIBLE, ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$1,340 (Part A deductible) \$335 a day \$670 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 *** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. **This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,240 deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,240 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$2,240 DEDUCTIBLE, ** YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$183 of Medicare Approved Amounts *	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts *	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

PARTS A AND B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,240 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$2,240 DEDUCTIBLE, ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable Medical Equipment First \$183 of Medicare-approved amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,240 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO \$2,240 DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$1,340 (Part A deductible) \$335 a day \$670 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 ** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0 \$0 100%	Up to \$167.50 a day \$0 \$0 All costs	\$0 \$0 All costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$183 of Medicare Approved Amounts *	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts *	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN G
PARTS A AND B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable Medical Equipment First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN N
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st through 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$1,340 All but \$335 a day All but \$670 a day \$0 \$0	\$1,340 (Part A deductible) \$335 a day \$670 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 ** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days 21 st through 100 th day 101 st day and after	All approved amounts All but \$167.50 a day \$0 \$0 100%	Up to \$167.50 a day \$0 \$0 All costs	\$0 \$0 All costs
BLOOD First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

*Once you have been billed \$183 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$183 of Medicare Approved Amounts * Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$183 (Part B deductible) up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts) BLOOD First 3 pints Next \$183 of Medicare-approved amounts * Remainder of Medicare-approved amounts	\$0 \$0 \$0 80%	\$0 All costs \$0 20%	All costs \$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN N
PARTS A AND B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable Medical Equipment First \$183 of Medicare-approved amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary Emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Open Enrollment and Guaranteed Issue Worksheet

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

ELIGIBILITY FOR OPEN ENROLLMENT

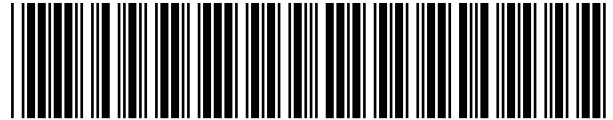
Applicant is:

- at least 64 1/2 years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

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

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.



Applicant:

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

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

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

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

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

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

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

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

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

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

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

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

Acceptable Evidence of Eligibility:

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

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UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan **Applicant A** _____

Applicant B _____

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

	Steps	Example Sample rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	<p>Age Write in your age at the time of signing the application.</p> <p>ZIP Code Indicate your ZIP Code used to determine your rate.</p>	<p>65</p> <p>78798</p>		
#2	<p>Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.</p>	\$98.10		
#3	<p>Household Premium Discount Please refer to the application for state specific household discount premium rules.</p> <p>If the rules apply, multiply the amount from Step #2 by .88. If the rules do not apply, enter the amount from Step #2.</p>	<p>$\\$98.10 \times .88 = \\86.33</p> <p>In this example, the person qualifies for the household premium discount.</p>		
#4	<p>Rate Adjustment <i>If you're in your open enrollment or guaranteed issue period, skip to Step #5.</i></p> <p>Locate your height, then weight, on the next page.</p> <ul style="list-style-type: none"> If your weight is in the Standard column, enter the amount from Step #3 If your weight is in a Decline column, you are ineligible for coverage. 			
#5	<p>Payment Options Your monthly payment is your last premium entered (Step #3 or #4).</p> <p>To determine other payment schedules, multiply your monthly premium by:</p> <p>3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)</p>	<p>\$86.33 monthly payment</p> <p>\$258.98 quarterly payment \$517.98 semiannual payment \$1,035.96 annual payment</p>		

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Height and Weight Chart

Eligibility

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

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	55 – 145	146 +
4' 3"	< 56	57 – 151	152 +
4' 4"	< 58	59 – 157	158 +
4' 5"	< 60	61 – 163	164 +
4' 6"	< 63	64 – 170	171 +
4' 7"	< 65	66 – 176	177 +
4' 8"	< 67	68 – 182	183 +
4' 9"	< 70	71 – 189	190 +
4' 10"	< 72	73 – 196	197 +
4' 11"	< 75	76 – 202	203 +
5' 0"	< 77	78 – 209	210 +
5' 1"	< 80	81 – 216	217 +
5' 2"	< 83	84 – 224	225 +
5' 3"	< 85	86 – 231	232 +
5' 4"	< 88	89 – 238	239 +
5' 5"	< 91	92 – 246	247 +
5' 6"	< 93	94 – 254	255 +
5' 7"	< 96	97 – 261	262 +
5' 8"	< 99	100 – 269	270 +
5' 9"	< 102	103 – 277	278 +
5' 10"	< 105	106 – 285	286 +
5' 11"	< 108	109 – 293	294 +
6' 0"	< 111	112 – 302	303 +
6' 1"	< 114	115 – 310	311 +
6' 2"	< 117	118 – 319	320 +
6' 3"	< 121	122 – 328	329 +
6' 4"	< 124	125 – 336	337 +
6' 5"	< 127	128 – 345	346 +
6' 6"	< 130	131 – 354	355 +
6' 7"	< 134	135 – 363	364 +
6' 8"	< 137	138 – 373	374 +
6' 9"	< 140	141 – 382	383 +
6' 10"	< 144	145 – 392	393 +
6' 11"	< 147	148 – 401	402 +
7' 0"	< 151	152 – 411	412 +
7' 1"	< 155	156 – 421	422 +
7' 2"	< 158	159 – 431	432 +
7' 3"	< 162	163 – 441	442 +
7' 4"	< 166	167 – 451	452 +

Medicare supplement insurance is underwritten by
UNITED WORLD LIFE INSURANCE COMPANY
 A MUTUAL of OMAHA COMPANY
 Mutual of Omaha Plaza
 Omaha, Nebraska 68175
mutualofomaha.com



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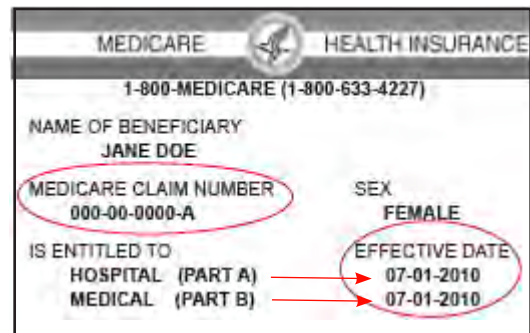
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B. Applicant Information (continued)

Applicant A	Applicant B
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will <u>not</u> receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United World Life Insurance Company.	
Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N	Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>

D. Household Premium Discount Information

	Applicant A	Applicant B
You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.		
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months; or (b) with whom you reside and to whom you are married?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.		
Name (First/Middle/Last)		
Date of Birth		
Street Address		
City/State/ZIP		

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E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:		Applicant A	Applicant B
3. Are you covered for medical assistance through the state Medicaid program?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(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.)			
If "YES," answer the following about this existing coverage:			
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
If "YES," answer the following about this existing coverage:			
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A	<input type="text"/>	<input type="text"/>
	Applicant B	<input type="text"/>	<input type="text"/>
(c) With what company, and what plan do you have?			

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

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

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



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

Check box(s) below if applicable

Applicant A	Applicant B
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please answer questions regarding other health insurance:

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

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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

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

Applicant A	START	/ /
	END	/ /
Applicant B	START	/ /
	END	/ /



(b) Planned date of termination/disenrollment?.....

Applicant A	/ /
Applicant B	/ /

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

<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
-------------------------------------------------------	-------------------------------------------------------

(d) Please state the reason for your disenrollment:

Applicant A _____

Applicant B _____

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

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

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

7. Are you applying during a guaranteed issue period?.....
(NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible.
If the answer above is "YES," attach proof of eligibility.)
8. Did you turn age 65 in the last six months?.....
9. Did you enroll in Medicare Part B in the last six months?.....

Applicant A	Applicant B
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

If "YES," indicate your Medicare Part B effective date.....

Applicant A	/ /
Applicant B	/ /



IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

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

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

G. Health Information



For all plans, answer questions 10-20.

Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 10-16, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
10. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following (Do not include surgery when answering G):		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic lupus, scleroderma or myasthenia gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have Osteoporosis, and as a result, experienced a fracture?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or kidney disease?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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

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

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

H. Medication Information



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

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
1. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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I. Agreement and Authorization



IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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.
- 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.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED WORLD LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United World Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United World Life Insurance Company, 3316 Farnam Street, Omaha, NE 68175. I realize that my right to revoke this authorization is limited to the extent that United World Life Insurance Company has taken action in reliance on the authorization or the law allows United World Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- “Personal Information” means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant’s policy.

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

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

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Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant A’s Signature

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant B’s Signature (if applying)



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

Multiple empty horizontal lines for entering producer comments.

K. To be Completed by Producer

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

Form for listing policies/certificates still in force, with sections for Applicant A and Applicant B.

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

Form for listing policies/certificates no longer in force, with sections for Applicant A and Applicant B.

I/We certify as follows:

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

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

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

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

Signature of Licensed Producer Date

Signature of Licensed Producer Date

Printed Name

Printed Name

Agent Writing Number grid

Agent Writing Number

Agent Writing Number grid

Agent Writing Number

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I. Select Premium Payment Option

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

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

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

Part II. Payor Information

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

Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:

This section is intended as authorization to debit your bank account.

Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here	Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____	Applicant B <input type="checkbox"/> Same account as Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____
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- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.





Example:

Account Holder Name	Do NOT include the check # in the Routing or Account Number.
John Doe	Check #1234
Street Address	Date: _____
Town, City ZIP Code	Pay to: _____ Dollars
Routing/Transfer Number	Account Number
Financial Institution Name & Address	Signed By: _____
⑆123456789⑆ 12345678 ⑆ 1234 ⑆	

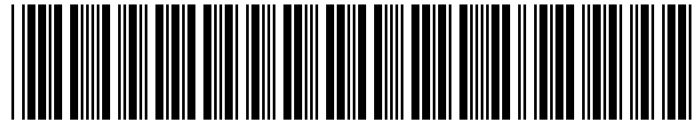
W27785_0314

Part III. Account Information (continued)

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

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





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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing issuer, 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 the benefits provided under 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):

<p>Applicant</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p>	<p>Applicant B</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums 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 until you have received your new policy and are sure that you want to keep it.

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

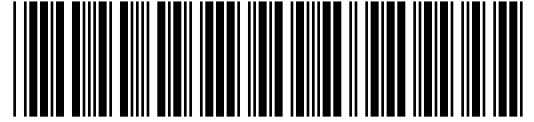
UNITED WORLD LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

UNITED WORLD LIFE INSURANCE COMPANY

Medicare Select Policy Disclosure Agreement



I acknowledge receipt of the following information:

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

I also understand the following:

United World Life Insurance Company does not recommend the purchase of a Medicare select policy if I live more than 20-25 miles from a network hospital; unless the network hospital is the closest hospital which offers this level of service.

Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses.

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

Signature of the Proposed Applicant	Signature of the Proposed Applicant B
Date	Date

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

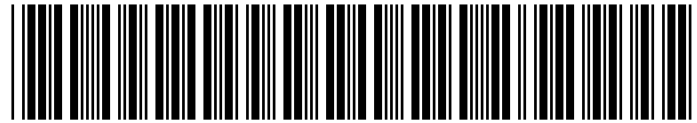
As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

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

Definition of Eligible Person for Guaranteed Issue

Premium Receipt



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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing issuer, 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 the benefits provided under 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):

<p>Applicant</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p>	<p>Applicant B</p> <p><input type="checkbox"/> Additional benefits</p> <p><input type="checkbox"/> No change in benefits, but lower premiums</p> <p><input type="checkbox"/> Fewer benefits and lower premiums</p> <p><input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> Disenrollment from a Medicare Advantage Plan</p> <p><input type="checkbox"/> Please explain reason for disenrollment</p> <p><input type="checkbox"/> Other (please specify)</p> <p>_____</p> <p>_____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums 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 until you have received your new policy and are sure that you want to keep it.

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

UNITED WORLD LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	Applicant B
Signature	Signature
Date	Date

*Signature not required for direct response sales.

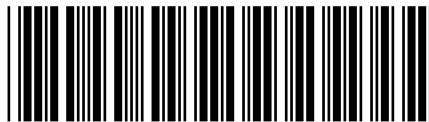
UNITED WORLD LIFE INSURANCE COMPANY

Definition of Eligible Person for Guaranteed Issue

The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

- (a) Enrolled under an employee welfare benefit plan and the plan terminates or ceases to provide benefits or the individual is no longer eligible for the plan;
- (b) Enrolled in a Medicare Advantage plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or choice contract, or a Medicare Select plan and then the insured person terminates coverage within 12 months of enrollment, or
- (f) Upon first becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare Advantage or in a PACE Program and disenrolls within 12 months.
- (g) Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminated enrollment in the Medicare supplement policy.
- (h) Loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete the Application for Medicare supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.



UNITED WORLD LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Premium Receipt

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

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

Applicant A

Received from _____

this ____ day of _____, _____

an application for Form _____ Policy

and/or Riders _____ and _____

Check for _____ Dollars.

 Agent _____

Applicant B

Received from _____

this ____ day of _____, _____

an application for Form _____ Policy

and/or Riders _____ and _____

Check for _____ Dollars.

 Agent _____

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



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



**APPLICATION for
INDIVIDUAL DENTAL INSURANCE
WITH OPTIONAL VISION RIDER**

TEXAS

MUTUAL OF OMAHA INSURANCE COMPANY

3300 Mutual of Omaha Plaza, Omaha, NE 68175



Monthly Rates (Issue Age 19-99)

TEXAS			
ZIP Codes	Mutual Dental Preferred DNT2	Mutual Dental Protection DNT5	Vision Rider OPD1M-41
754-759, 764, 768, 776-781, 783-785, 790, 791, 793-799	\$43.66	\$24.96	\$8.28
760-763, 765-767, 769, 770, 774, 775, 782, 788, 789, 792	\$49.06	\$28.05	\$8.28
733, 750-753, 771-773, 786, 787, 885	\$50.53	\$28.89	\$8.28

Rates Subject to Change.

As of 10/7/2017

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to \$50 every calendar year for one eye exam (no waiting period)

Up to \$150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

MUTUAL OF OMAHA INSURANCE COMPANY

3300 Mutual of Omaha Plaza, Omaha, NE 68175

Internal Tracking Code _____
Group # (if applicable) _____



Application for Individual Dental Insurance with Optional Vision Rider

A. Applicant Information

Name (First, Middle Initial, Last)		Phone Number Home _____ Cell _____	
Residence Address (Street, City, State, ZIP)		E-mail _____	
Mailing Address (Street, City, State, ZIP) (if different from residence address)		Deliver Policy to <input type="checkbox"/> Applicant <input type="checkbox"/> Producer	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	Social Security Number _____	

B. Plan Information

Select Dental Benefit Plan <input type="checkbox"/> Mutual Dental Preferred Annual Maximum \$1,500 <input type="checkbox"/> Mutual Dental Protection Annual Maximum \$1,000 <input type="checkbox"/> Optional Vision Rider (only available with Dental)	Requested Effective Date _____ Monthly Premium Rate for Dental \$ _____ Monthly Premium Rate for Vision \$ _____ Total Monthly Premium \$ _____
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

C. Existing Coverage Information

Are you covered by any other dental or vision insurance? Y N

If Yes, answer the following about this existing coverage:

Name of dental carrier(s) _____


Name of vision carrier(s) _____

Is the coverage you are applying for replacing existing dental insurance? Y N


Is the coverage you are applying for replacing existing vision insurance? Y N

D. Agreements


I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

 _____
Applicant Signature _____ Date _____ Signed at _____ City _____ State _____

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

 _____
Signature of Licensed Insurance Producer _____ Date _____

Printed Name _____ Agent Writing Number _____ Comm. % Share _____%

 _____
Signature of Licensed Insurance Producer _____ Date _____

Printed Name _____ Agent Writing Number _____ Comm. % Share _____%



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Part III. Account Information (continued)

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

Applicant



Authorized Signature as Shown on Account

Date



Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175



According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/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, reread it carefully to be certain that all information has been properly recorded.

The above Notice to Applicant was delivered to me on _____
Date

Applicant's Signature



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Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175



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Date

Applicant's Signature



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**MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600**

**LIMITED BENEFIT DENTAL COVERAGE ONLY
OUTLINE OF COVERAGE FOR POLICY SERIES DNT2
INDIVIDUAL DENTAL NETWORK INSURANCE**

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you **ONLY** with limited benefit dental insurance coverage. Coverage is **NOT** provided for any other diseases or accidents.

Benefits – This is a network dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/dental-insurance.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	\$50.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	50%
WAITING PERIOD	TIME FRAME
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	1 Year

MAXIMUM BENEFIT	AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500.00
Implant Lifetime Maximum Benefit	\$3,000.00

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

Waiting Period – Class III covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (d) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (o) office infection control charges;

- (p) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- (q) state, federal, or territorial taxes on dental services performed;
- (r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (u) those dental services which are for specialized procedures and techniques;
- (v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (w) duplicate, provisional and temporary devices, appliances, and services;
- (x) plaque control programs, oral hygiene instruction, and dietary instructions;
- (y) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
 1. equilibration;
 2. periodontal splinting;
 3. full mouth rehabilitation and;
 4. restoration for misalignment of teeth;
- (z) gold foil restorations;
- (aa) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (cc) charges by the provider for completing dental forms;
- (dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ee) use of material or home health aids to prevent decay, such as:
 1. toothpaste;
 2. fluoride gels;
 3. dental floss and;
 4. teeth whiteners;
- (ff) sealants;
- (gg) precision attachments, personalization, precious metal bases and other specialized techniques;
- (hh) replacement of dentures that have been:
 1. lost;
 2. stolen or;
 3. misplaced;
- (ii) repair of damaged orthodontic appliances;
- (jj) replacement of lost or missing appliances;
- (kk) fabrication of athletic mouth guard;
- (ll) internal bleaching;
- (mm) nitrous oxide;
- (nn) oral sedation;
- (oo) topical medicament carrier;
- (pp) orthodontic services, treatment or supplies, including braces and retainers;
- (qq) bone grafts when done in connection with:
 1. extractions;
 2. apicoectomies or;

- 3. non-covered/non-eligible implants;
- (rr) tooth whitening;
- (ss) occlusal guards;
- (tt) space maintainers;
- (uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium when it is due.

Grace Period – Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period.

Premiums Can Change – We will not increase your policy’s premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Total premium amount _____

**MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600**

**LIMITED BENEFIT DENTAL COVERAGE ONLY
OUTLINE OF COVERAGE FOR POLICY SERIES DNT5
INDIVIDUAL DENTAL NETWORK INSURANCE**

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a network dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/dental-insurance.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services, Class II – Basic Services and Class III – Major Services Combined	\$100.00
COINSURANCE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	50%
WAITING PERIOD	TIME FRAME
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	1 Year
MAXIMUM BENEFIT	AMOUNT

Annual Maximum Benefit per Calendar Year	\$1,000.00
Implant Lifetime Maximum Benefit	\$2,000.00

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

Waiting Period – Class III covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

- (a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
- (b) services or treatment not prescribed by or under the direct supervision of a dentist;
- (c) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- (d) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- (o) office infection control charges;

- (p) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/ mailing copies of your records, charts or x-rays;
- (q) state, federal, or territorial taxes on dental services performed;
- (r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (u) those dental services which are for specialized procedures and techniques;
- (v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (w) duplicate, provisional and temporary devices, appliances, and services;
- (x) plaque control programs, oral hygiene instruction, and dietary instructions;
- (y) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
 1. equilibration;
 2. periodontal splinting;
 3. full mouth rehabilitation and;
 4. restoration for misalignment of teeth;
- (z) gold foil restorations;
- (aa) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- (bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (cc) charges by the provider for completing dental forms;
- (dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ee) use of material or home health aids to prevent decay, such as:
 1. toothpaste;
 2. fluoride gels;
 3. dental floss and;
 4. teeth whiteners;
- (ff) sealants;
- (gg) precision attachments, personalization, precious metal bases and other specialized techniques;
- (hh) replacement of dentures that have been:
 1. lost;
 2. stolen or;
 3. misplaced;
- (ii) repair of damaged orthodontic appliances;
- (jj) replacement of lost or missing appliances;
- (kk) fabrication of athletic mouth guard;
- (ll) internal bleaching;
- (mm) nitrous oxide;
- (nn) oral sedation;
- (oo) topical medicament carrier;
- (pp) orthodontic services, treatment or supplies, including braces and retainers;
- (qq) bone grafts when done in connection with:
 1. extractions;
 2. apicoectomies or;

- 3. non-covered/non-eligible implants;
- (rr) tooth whitening;
- (ss) occlusal guards;
- (tt) space maintainers;
- (uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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Premiums Can Change – We will not increase your policy’s premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Total premium amount _____