



## Application Submission Checklist To United World For Medicare Supplement Coverage – CALIFORNIA

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

- Application**
  1. Complete “Plan Information” Box
  2. Refer to the Outline of Coverage for policy forms.
  3. Answer all questions in full.
  4. Sign and Date in all places indicated.
  5. Be sure to leave all applicable forms with the proposed insured.
  6. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
  - The full modal premium is collected at the time of application.
  - Calculate the premium based on age at time of application.
- Provide Client with Buyer’s Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- Complete Bank Service Plan (BSP) Authorization (if applicable)**
- Provide Client with Official Receipt signed by agent**
- When Replacing a Product With a United World or Mutual of Omaha Product, Please Complete the Authorization To Disclose Personal Information (W24903)**
- Complete Replacement Notice (W25776) and leave a copy with the applicant (if applicable)**
- Complete Senior 24-hour meeting Notice (W25784) and leave with the applicant**

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

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

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

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

## 1. Application

### Agent Completes in Full: (please print)

#### "Plan Information" Box

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

\*Direct Monthly billing not available

#### Part I "General Information"–

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

#### Part II "Existing Coverage Information"–

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

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

## 2. Administrative Forms

### Producer Information

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

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

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

### Receipt

- Detach and leave with applicant.

### Authorization To Disclose Personal Information

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

### Replacement Notice – complete if applicable

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

### State – Specific Forms – complete if applicable

- Be sure to include all state appropriate forms.



Mgr./Commission Code (Required Field For Brokerage) <b>86</b>	District Sales Manager/Assoc. Marketer	Application Reviewed By:
<b>PLAN INFORMATION (to be completed by Producer)</b>		
Policy Form	Requested Effective Date:	
Spouse applying for coverage (different application)? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Premium Collected \$	Initial Mode A, S, Q or B	
Renewal \$	Renewal Mode A, S, Q or B (monthly not allowed)	

## Application To United World Life Insurance Company For Medicare Supplement Coverage

### PART I. GENERAL INFORMATION (Must be completed in ink!)

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

### PART II. EXISTING COVERAGE INFORMATION (COMPLETE IN FULL)

To the best of your knowledge:

- Are you covered under Medicare? ..... Part A: Yes  No  Part B: Yes  No   
If "Yes," give your Medicare card number. \_\_\_\_\_ If "No," when will you become eligible? \_\_\_\_\_  
Mo. Day Yr.
- Did you turn age 65 in the last 6 months? ..... Yes  No
- Did you enroll in Medicare Part B in the last 6 months? ..... Yes  No   
If "Yes," indicate your effective date. \_\_\_\_\_ If "No," indicate date you plan to enroll. \_\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.
- Are you applying during a guaranteed issue period? ..... Yes  No

(NOTE: If the answer above is "Yes" please attach proof of eligibility.)

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

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

Name of Company	Kind of Policy

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

START \_\_\_\_ / \_\_\_\_ / \_\_\_\_ END \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(c) Reason for termination/disenrollment? \_\_\_\_\_

(d) Date of termination/disenrollment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- 7. (a) Do you have another Medicare Supplement insurance policy or certificate or health care service plan in force?....Yes  No 
(b) If so, with what company, and what plan do you have?

Table with 4 columns: Name of Company, Policy/Certificate Number, Plan, Issue Date

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

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

- 8. Are you covered for medical assistance through the state Medicaid or Medi-Cal or program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)....Yes  No 
If yes, (a) Will Medi-Cal or Medicaid pay your premiums for this Medicare Supplement policy?.....Yes  No 
(b) Do you receive any benefits from Medicaid or Medi-Cal OTHER THAN payment toward your Medicare Part B premium?.....Yes  No

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

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

Table with 4 columns: Name of Company, Policy/Certificate Number, Description of Benefits, Effective Date of Coverage

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

Table with 4 columns: Name of Company, Policy/Certificate Number, Description of Benefits, Effective Date of Coverage

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

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

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

(n) Have you had an organ transplant or been advised by a physician to have an organ transplant? .....

2. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? ..... Yes  No

If "Yes," please list the drug and the condition. (Use page 4 of application, if more space is necessary.)

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

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

**PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- (a) You do not need more than one Medicare Supplement policy.
- (b) If you purchase this policy, you may want to evaluate your existing health coverages and decide if you need multiple coverage.
- (c) You may be eligible for benefits under Medicaid or Medi-Cal and may not need a Medicare Supplement policy.
- (d) If, after purchasing the policy, you become eligible for Medicaid or Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid or Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid or Medi-Cal. If you are no longer entitled to Medicaid or Medi-Cal, 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 or Medi-Cal eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (e) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (f) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free telephone number (1-800-927-HELP), your local HICAP office, or by accessing the Department of Insurance's Internet web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)).

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



### Producer(s) Information

Producer Name: \_\_\_\_\_ Social Security No. 547-39-0801  
Comm. % Share: \_\_\_\_\_ Producer Phone No. (\_\_\_\_) \_\_\_\_\_ Commission Code: 0431579  
Producer E-mail Address: \_\_\_\_\_ @ \_\_\_\_\_

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

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

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

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

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

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

## Authorization to Withdraw Funds by United World Life Insurance Company (BSP)

### ATTENTION: PLEASE READ CAREFULLY

Complete the Bank Service Plan below and submit with the application if premium payments are to be withdrawn from the applicant's bank account.

#### How To Sign up for the Bank Service Plan

1. Complete the form, making sure to write your name below as shown on your checking account.
2. Include your check for the first month's payment with your completed form. We'll use the account number on your check to put your monthly Bank Service Plan payments into effect. So it's important your check is from the account you want your payments withdrawn from.

**Complete the following only if you are adding the above coverages to an existing BSP account.**

\_\_\_\_\_  
Name of Insured Under Existing BSP

\_\_\_\_\_  
Existing BSP Policy Number

Specify Date of Withdrawals:     1<sup>st</sup> of the Month     15<sup>th</sup> of the Month

#### **Important! Fill in and return if you want your bank to make monthly insurance payments for you.**

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED WORLD LIFE INSURANCE COMPANY, Omaha, Nebraska. As a convenience to me, I authorize you to pay and charge to my account any checks, drafts or preauthorized electronic fund transfer made upon my account by, and payable to the order of, United World Life Insurance Company. I agree that your rights with respect to each charge will be the same as if it were personally executed by me. This authorization is to remain in effect until I give you, my financial institution, at least three business days' notice to revoke it, provided, however, if notice is given orally, then you may require a written confirmation from me within 14 days after the oral notification.

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Authorized Signature as Shown on Account

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Joint Account or Other Authorized Signature

Your premiums will be withdrawn monthly from your checking account on the date you've checked above.

## Official Receipt

### Check or Money Order Application

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

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

Received of \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ an application

for a Form \_\_\_\_\_ Policy and Riders \_\_\_\_\_

and Check or Money Order for \_\_\_\_\_ Dollars.

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

Agent \_\_\_\_\_

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

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

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

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

## Authorization To Disclose Personal Information To United World Life Insurance Group

### MEANINGS OF TERMS

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

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

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

**"Specified Companies" means:**

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

### AUTHORIZATION TO DISCLOSE

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

### PURPOSES

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

### POTENTIAL FOR REDISCLOSURE

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

### FAILURE TO SIGN

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

### EXPIRATION AND REVOCATION

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

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

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

### COPY

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

### NAMES AND SIGNATURES

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

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

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

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

If you intend to cancel or terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with coverage issued by United World Life Insurance Company, please review the new coverage carefully and replace the existing coverage **ONLY** if the new coverage materially improves your position. **DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.**

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare Supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

**Statement to Applicant from the insurer and agent:** I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

- Additional benefits that are: \_\_\_\_\_
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- Other reasons specified here: \_\_\_\_\_

**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)\*

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

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

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- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
- Other reasons specified here: \_\_\_\_\_

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\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)\*

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

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

UNITED WORLD LIFE INSURANCE COMPANY  
A MUTUAL of OMAHA COMPANY

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Dear \_\_\_\_\_

Thank you for agreeing to meet with me on \_\_\_\_\_  
Date Time

During this meeting, or a follow-up meeting, we will be discussing the following:

A sales presentation on:

- Life insurance
- Annuities
- OTHER insurance \_\_\_\_\_

In Addition:

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

You have the right to contact the Department of Insurance for information, or to file a complaint at 1-800-927-4357.

The following individuals will be coming to your home:

\_\_\_\_\_  
Name License #

\_\_\_\_\_  
Name License #

Sincerely,

\_\_\_\_\_  
United World Representative

Life Insurance and Annuities Underwritten by United of Omaha Life Insurance Company  
Health Insurance Underwritten by Mutual of Omaha Insurance Company  
Both at Mutual of Omaha Plaza, Omaha NE, 68175

W25784