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

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

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

Submission Options

For your convenience, there are a coupl of ways in which you can complete and submit the form:

- Recommended – An electronic version can be completed online at *www.mutualofomaha.com/eoi*
- A "fillable" PDF version is available online at *www.mutualofomaha.com/module/gforms.phtml*. This version allows you to type information into the form (to ensure responses are fully legible), then print, sign and mail the application.

Important Tips for Paper Copy Submission

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

Guidelines for Section 1: Employer Information

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

Guidelines for Section 2: Employee Contact & Employment Information

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

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

Guidelines for Section 3: Applicant Information

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

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

Guidelines for Section 4: Requested Coverage Amount

Helpful Hints for (1) Current Amount of Insurance

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

Helpful Hints for (2) Additional Requested Amount

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

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

Guidelines for Section 5: Health Information for Applicants

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

If you are only applying for coverage for yourself, then answer these questions for yourself only. If you are applying for coverage for any dependents, then answer these questions for anyone included on the form.

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

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

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

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

NOTICE OF INFORMATION PRACTICES

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

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

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

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

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

MIB GROUP, INC. PRE-NOTICE

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

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

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

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

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

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

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

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

INVESTIGATIVE CONSUMER REPORTS NOTICE

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

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

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

Group Life Insurance
Evidence of Insurability Form

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

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

Employer's Name*	**Group ID Number***
ALTMAN SPECIALTY PLANTS	G000 C 8 B R

Street Address	**Telephone (xxx) xxx-xxxx**

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

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

Last Name*	**First Name***	**Middle Name**

Street Address*	**Email Address**

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

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

Consent to Email Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this form via email.

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

Part A – Complete if the Employee is Applying for Coverage

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

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

Last Name*	**First Name***	**MI**

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

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

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

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

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

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

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

Part A – Health Questions: Please answer questions 1 through 5 to the best of your knowledge and belief. If you respond "Yes" to any of these questions, please complete the Medication Information sheet on the next page.

Health Question 1	**Response**
Within the past five years have you been diagnosed or treated by a medical professional for, or had surgery for any of the following:	
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ YES ☐ NO
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), chronic pulmonary disease or cardio-pulmonary disease requiring oxygen?	☐ YES ☐ NO
C. Alzheimer's Disease, dementia or any other cognitive disease?	☐ YES ☐ NO
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?	☐ YES ☐ NO
E. Systemic Lupus or Myasthenia Gravis?	☐ YES ☐ NO
F. 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. Please do not provide information regarding your HIV status.**	☐ YES ☐ NO
G. Chronic hepatitis or cirrhosis?	☐ YES ☐ NO
H. Osteoporosis with fractures?	☐ YES ☐ NO
Health Question 2	**Response***
Within the past five years been diagnosed or treated by a medical professional for diabetes?	☐ YES ☐ NO
Health Question 3	**Response***
Within the past five years been diagnosed or treated by a medical professional for:	
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ YES ☐ NO
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve, atrial fibrillation, abnormal heart rhythm, or implantation of a pacemaker?	☐ YES ☐ NO
C. High blood pressure / hypertension?	☐ YES ☐ NO
D. Alcoholism or drug abuse?	☐ YES ☐ NO
E. A mental or nervous disease requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ YES ☐ NO
F. Internal cancer, lymphoma or melanoma?	☐ YES ☐ NO
G. A stroke or transient ischemic attack (TIA)?	☐ YES ☐ NO
H. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis or arthritis that restricts mobility?	☐ YES ☐ NO
I. A joint replacement?	☐ YES ☐ NO
Health Question 4	**Response***
Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ YES ☐ NO
Health Question 5	**Response***
Have you taken any prescription drugs in the past 24 months?	☐ YES ☐ NO

Part B – Medical Information
If you responded YES to any Health Question under Part A on the previous page, you must provide the following, information, as applicable.

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

Section 6: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

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

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

Part A – Definitions of Terms Used in Section 7

I or **me** means each person signing below in Part C of Section 7, except where otherwise noted.

MIB Group, Inc. (MIB) means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.

Personal Information means information about me and/or any dependent child applying for coverage, including health information medical history, mental and physical condition, drug and alcohol use, motor vehicle reports and criminal activity.

Part B – Authorization to Disclose Personal Information

To the MIB: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

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

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

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

_____

Part C – Application for Insurance

If I am an eligible employee applying for insurance, I apply for life insurance for me and any child who is has not yet attained age 18 identified in Section 3 of this form who is eligible for insurance. If I am an eligible child, age 18 or greater, of the employee applying for insurance, I apply for life insurance for me. If I am an eligible spouse of the employee applying for insurance, I apply for life insurance for me.

I understand that any insurance for a person applying for insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approves such person for such amounts. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete.

I (the employee) permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until the employee's insurance certificate is issued or amended and the first premium paid.

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

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

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

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

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

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

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

***Child signature required only if child is 18 years of age or older.**

Section 8: Form Submission

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

Attn: Group Underwriting Individual Selection
Mutual of Omaha
3300 Mutual of Omaha Plaza
Omaha, NE 68175

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

EMPLOYEE NAME* _____

Section 5 – Part B Addendum: Health Information for Applicants				
Ques. #	**Name of Applicant**	**Date of Occurrence** (MM/DD/YYYY)	**Date of Recovery** (MM/DD/YYYY)	**Condition, Injury, Diagnosis, Prescription and/or Findings of Exam**

California Fraud Warning

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