MUTUAL OF OMAHA INSURANCE COMPANY

Mutual Care® *Plus*

Application for Individual Long-Term Care Insurance

ARIZONA

Application Package Contains:

Required Forms to be Submitted			
Long-Term Care Personal Worksheet	Must complete, sign and submit with application. This worksheet helps determine whether a Long-Term Care policy is suitable.		
Application	1. Sections A-F must be answered in full. Notes: Any changes must be initialed. Check height/weight build chart to ensure client eligibility. 2. Choose to complete either Section G or H. 3. Section I - Enter the amount of premium and billing mode. Notes: At least two months premium must be submitted with monthly mode. If another mode is selected, submit applicable premium for that mode. There is no policy fee. 4. Sections J-K must be answered in full.		
Authorization to Disclose Personal Information (HIPAA)	Producer Statement	Temporary Insurance Agreement and Receipt *(applicable if check received with app)*	Replacement Notice *(if applicable)*

Required Forms to be Left with Applicant(s)			
Replacement Notice *(if applicable)*	Temporary Insurance Agreement and Receipt *(applicable if check received with app)*	MIB Inc. Pre-Notice, Company Notice of Information Practices, Investigative Consumer Reports Notice	
Long-Term Care Insurance Potential Rate Increase Disclosure Form	Things You Should Know Before You Buy Long-Term Care Insurance	Partnership Notice	Outline of Coverage

Not Contained within this Application Package:

Required Forms to be Left with Applicant(s) that are Not Included within this Package	
LTC Shopper's Guide *(Not included within this package. Please provide in addition.)*	Guide to Medicare for People Age 65 and Older *(Not included within this package. If applicable, please provide in addition.)*

Inform your client(s) that we will conduct a telephone interview or face to face interview. Provide them a copy of "***Preparing for the Personal Health Interview***" included as last page of this package.

After completing the application, you, the producer, should call 1-866-544-1617 to initiate the Personal Health Interview.

Unanswered questions on the application or missing or incomplete forms will result in underwriting delays as we attempt to secure the information.

If a ***question does not apply*** to your client, answer it as "No" or "None" rather than "N/A."

If the applicant answers "Yes" to any question in ***Section D***, he/she is ineligible for coverage.

If after review of our application and underwriting guide you are unable to determine how underwriting will handle a case, you may obtain additional guidance by calling 1-800-551-2059 or by sending an e-mail to ltcunderwriting@mutualofomaha.com. Please do not call or e-mail until you have reviewed both the application and our underwriting guide to learn how we will handle the specific condition(s). To discuss a potential client the underwriter will need to know the client's age, height and weight, tobacco status for the past two years, all medications, all health conditions, and whether or not the client has previously been declined for coverage, and if so, why.

Submit the fully completed application, and applicable completed forms to:

For regular mail submission:	**For overnight submission:**
Long-Term Care Service Office	Long-Term Care Service Office
P.O. Box 64901	7805 Hudson Rd., Ste. 180
St. Paul, MN 55164-0901	Woodbury, MN 55125-1591

For Fax submission, you, the producer, must:

- Use the **maximum resolution** to ensure the readability of the application/forms;
- Fax to **1-888-539-4672** and verify that the correct fax number is dialed to protect the privacy of the information contained in the application/forms;
- Send a **copy of the initial premium check** as the last page of the fax;
- **Retain the initial premium check** collected with the application until a policy number has been assigned. A policy number is usually assigned within three workdays and can be found on Sales Professional Access status reports. Then write the policy number on the check and mail the check to: Mutual of Omaha, P.O. Box 30154, Omaha, NE 68103-1254; and
- **Retain the original application/forms** in a secured location for at least 90 days to ensure we get through the underwriting process and avoid any legibility issues. Do not also send a paper copy of a faxed application/forms.

Long-Term Care Insurance

Personal Worksheet

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

People buy long-term care insurance for many reasons. Some do not want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) LTC09M Type of Policy: ☐ Guaranteed Renewable ☐ Noncancellable Single Premium

Applicant A

The premium for the coverage you are considering will be $_____ per month, or $_____ per year or a one-time single premium of $_____

Applicant B

The premium for the coverage you are considering will be $_____ per month, or $_____ per year or a one-time single premium of $_____

The Company's Right to Increase Premiums

The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state. Once your policy is paid up, the company cannot raise your rates.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy form since 2009. The company has not raised its premium rates on this policy form, but has on similar policy forms. The following is a summary of the rate increases for comprehensive coverage that the company has sold.

Policy Form*	Years Available for Purchase	Rate History
NH23/NH24	1987 - 1993	No Rate Increase
LTC1/LTM1	1992 - 1997	No Rate Increase
LT50/NH50	1997 - 2004	No Rate Increase
NHA/LTA/HCA	1998 - 2004	23% overall rate increase 2003
LTC04I	2004 - 2009	No Rate Increase
LTC04I7	2006 - 2009	No Rate Increase
LTC09M	2009 - Present	No Rate Increase

The rate increases listed above represent the overall comprehensive rate increases filed nationally in 2003. The availability, rate increase amounts, and dates of approvals vary by state.

*Or state equivalent.

Submit to LTC Service Office

Questions Related to Your Income

Applicant A	Applicant B
1. How will you pay each year's premium? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay	1. How will you pay each year's premium? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay
2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.	2. Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%? This is not applicable to single premium.
3. What is your annual income? (Check one) ☐ Under $16,000 ☐ $16,000 and over	3. What is your annual income? (Check one) ☐ Under $16,000 ☐ $16,000 and over
4. How do you expect your income to change over the next 10 years? (Check one) ☐ No Change ☐ Increase ☐ Decrease	4. How do you expect your income to change over the next 10 years? (Check one) ☐ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

5. Will you buy inflation protection? (Check one) ☐ Yes ☐ No If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay	5. Will you buy inflation protection? (Check one) ☐ Yes ☐ No If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of nursing home care in 2009 was $72,270, but this figure varies across the country. In ten years the national average annual cost would be about $117,720 if costs increase 5% annually.

6. What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.	6. What elimination period are you considering? Number of days _____ Approximate cost $_____ for that period of care.

Multiply the number of days with daily average for approximate cost of care. Reference cost of care sheet for state averages.

7. How are you planning to pay for your care during the elimination period? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay	7. How are you planning to pay for your care during the elimination period? (Check one) ☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Applicant A	Applicant B
1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one) ☐ Under $50,000 ☐ $50,000 and over	1. Not counting your home, about how much are all your assets (your savings and investments) worth? (Check one) ☐ Under $50,000 ☐ $50,000 and over
2. How do you expect your assets to change over the next 10 years? (Check one) ☐ Stay about the same ☐ Increase ☐ Decrease	2. How do you expect your assets to change over the next 10 years? (Check one) ☐ Stay about the same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets, not counting your home, are less than $50,000, you may wish to consider other options for financing your long-term care.

Submit to LTC Service Office

Disclosure Statement

Applicant A

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

Applicant B

(must check one)

☐ The answers to the questions on this Personal Worksheet describe my financial situation.

OR

☐ I choose not to complete this information. **You may be contacted by a company representative to confirm your decision.**

Applicant A

☐ **◀ THIS BOX MUST BE CHECKED**

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

X _____ _____

Signature of Applicant A Date

Applicant B

☐ **◀ THIS BOX MUST BE CHECKED**

I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

X _____ _____

Signature of Applicant B Date

I explained to the applicant(s) the importance of completing this information.

_____

Printed Name of Producer

X _____ _____

Signature of Producer Date

Authorization to Proceed when Income less than $16,000 or Assets less than $50,000

Applicant A

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

X _____ _____

Signature of Applicant A Date

Applicant B

My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

X _____ _____

Signature of Applicant B Date

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Individual Long-Term Care Insurance Application

Mutual *of* Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

Submit Application To: Long-Term Care Service Office, P.O. Box 64901, St. Paul, MN 55164-0901
Overnight Submission: Long-Term Care Service Office, 7805 Hudson Rd., Ste. 180, Woodbury, MN 55125-1591

☐ **New Business**
☐ **Reinstatement**
If Sponsored/Association, List Name and Service Group Number_____

Section A GENERAL INFORMATION

	Applicant A	Applicant B
1	**Name:** Last Name First Name / Middle Initial	**Name:** Last Name First Name / Middle Initial
2	**Legal Residence Address:** Number, Street, Apartment Number City, State, ZIP Code	**Legal Residence Address *(If Different than Applicant A)*:** Number, Street, Apartment Number City, State, ZIP Code
3	**Contact Information:** ( ) – ( ) – Daytime Phone Number / Evening Phone Number : a.m. : p.m. Best Time to Call E-mail Address	**Contact Information *(If Different than Applicant A)*:** ( ) – ( ) – Daytime Phone Number / Evening Phone Number : a.m. : p.m. Best Time to Call E-mail Address
4	**Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐	**Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐
5	**Birth Date, Age and Gender:** ☐☐ / ☐☐ / ☐☐☐☐ ☐☐ Month / Day / Year / Age ☐ Male ☐ Female	**Birth Date, Age and Gender:** ☐☐ / ☐☐ / ☐☐☐☐ ☐☐ Month / Day / Year / Age ☐ Male ☐ Female
6	**Occupation and Duties:** Occupation Occupational Duties	**Occupation and Duties:** Occupation Occupational Duties

Section A GENERAL INFORMATION (continued)

Applicant A	Applicant B
7 U.S. Citizenship:	**7 U.S. Citizenship:**
Are you a citizen of the United States? ☐ Yes ☐ No	Are you a citizen of the United States? ☐ Yes ☐ No
If **"No,"** do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?	If **"No,"** do you have a Permanent Resident Card – Form I-551 (also known as an "Alien Registration Receipt Card" or "Green Card")?
☐ Yes. Card Number_____	☐ Yes. Card Number_____
and Date of Arrival in the U.S. _____	and Date of Arrival in the U.S. _____
☐ No. You are not eligible for this coverage.	☐ No. You are not eligible for this coverage.
8 Beneficiary:	**8 Beneficiary *(If Different than Applicant A)*:**
_____ First Name, Middle Initial, Last Name	_____ First Name, Middle Initial, Last Name
_____ Number, Street, Apartment Number	_____ Number, Street, Apartment Number
_____ City, State, ZIP Code	_____ City, State, ZIP Code
_____ Relationship to you	_____ Relationship to you

Section B ALLOWANCES

You may be eligible for allowances based on your answers to the following questions in this Section B.

	Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
1 Are you married?	☐	☐	☐	☐
Do you have a Domestic Partner*?	☐	☐	☐	☐
If **"No,"** go to question 2. If **"Yes,"**:				
(a) Is your Spouse or Domestic Partner also applying for this coverage?	☐	☐	☐	☐
If **"Yes,"** provide name				
(b) Does he/she have an existing Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company long-term care policy/certificate?	☐	☐	☐	☐
If **"Yes,"** provide existing long-term care policy/certificate number(s)				
2 Are you single and have you been continuously residing with another person for the last 12 months and are they also applying for this coverage?	☐	☐	☐	☐
If **"Yes,"** provide name				
3 Do you have or are you applying for a Medicare Supplement policy/ certificate with Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company or United World Life Insurance Company?	☐	☐	☐	☐
If **"Yes,"** provide existing policy/certificate number(s)				
4 Are you a member, or qualified family member, of a Sponsored/ Association group endorsing this long-term care product?.....	☐	☐	☐	☐
If "Yes," provide Sponsored/Association Service Group Number _____				
Full Name of Organization _____				
Name and Relationship to Member_____				

* Domestic Partner means either of the following: (a) an adult person with whom you have registered or filed for domestic partnership in a civil union with a government agency or office where such registration is available, or (b) an adult person who meets the following criteria: (1) has a serious and committed personal relationship with you that is intended to be lifelong, (2) has shared a common permanent residence on a continuous basis with you for the most recent three years, and (3) is not married or legally separated, a Domestic Partner to anyone else or related to you in any way that would bar marriage in the state where you and he or she reside.

Section C REPLACEMENT COVERAGE

Provide Replacement Coverage Information.

		Applicant A		Applicant B	
		Yes	No	Yes	No
1	Do you currently have another long-term care insurance policy/certificate in force (including health care service contracts or health maintenance organization contracts)?	☐	☐	☐	☐
2	Did you have another long-term care insurance policy/certificate in force during the last 12 months?	☐	☐	☐	☐
3	Do you intend to replace other long-term care coverage or any of your medical or health insurance coverage with this policy? ..... If **"Yes,"** please read and sign the Notice to Applicant Regarding Replacement form included with this application.	☐	☐	☐	☐
4	**Question to be answered by the Producer:** Have you, **the Producer**, sold any health insurance, including long-term care policies, to Applicant A or Applicant B which: are still in force; or were sold in the last five years but are no longer in force?	☐	☐	☐	☐

If any question 1-4 was answered "Yes," in the above Section C, please provide details in C5 below.
(Attach additional signed page(s) if more space is needed.)

5 Applicant	Company Name/Address	Policy/ Certificate #	Plan Type *	Daily or Monthly Benefit	Status of Policy/Certificate	Annual Premium	To be Replaced by this Coverage	Sold by this Producer
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ A ☐ B				$	☐ Pending ☐ In Force ☐ Terminated ☐ Lapsed Ending Date ___/___/___	$	☐ Yes ☐ No	☐ Yes ☐ No

***** Provide Plan Type abbreviation: LTC=Long-Term Care, MS=Medicare Supplement, MM=Major Medical, OH=Other Health

		Applicant A		Applicant B	
		Yes	No	Yes	No
6	Have you ever been declined, rated, or denied reinstatement for long-term care insurance? ..... If **"Yes,"** provide details below. (Attach additional signed page(s) if more space is needed.)	☐	☐	☐	☐

Applicant	Company Name(s)	When	Why
☐ A ☐ B			
☐ A ☐ B			

Section D HEALTH INSURABILITY QUESTIONS

If you answer "Yes" to any of the questions in this Section D, we are unable to accept this application or offer you Long-Term Care Insurance. Do not continue.

		Applicant A		Applicant B	
		Yes	No	Yes	No
1	Do you currently use any of the following: ..... • wheelchair • walker • nebulizer • electric scooter • quad cane • oxygen	☐	☐	☐	☐
2	Within the past 6 months have you been confined to, or been advised to have, any of the following: ..... • residential care, assisted living or adult day care facility services • nursing home or home health care services • physical, occupational or speech therapy	☐	☐	☐	☐
3	Do you require the assistance or supervision of another person or a device of any kind for any of the following: ..... • bathing • toileting • dressing • eating • medication management • getting in and out of a chair or bed • your inability to control your bowel or bladder	☐	☐	☐	☐
4	Have you ever had, been diagnosed as having, or received medical advice or medical care from a physician or health care provider for any of the following: ..... • Alzheimer's Disease • Amyotrophic Lateral Sclerosis (ALS) • Chronic Hepatitis • Dementia • Huntington's Chorea • Cirrhosis • Memory Loss • Kidney Failure or received Dialysis • Myasthenia Gravis • Mental Retardation • Parkinson's Disease • Paralysis • Schizophrenia • Multiple Sclerosis • Scleroderma • Psychosis • Muscular Dystrophy • Systemic Lupus • Organ Transplant • Ministroke or Transient Ischemic Attack (TIA) in the past year, single episode stroke in the past 2 years, two or more strokes or TIAs, or you have not fully recovered or continue to have weakness, decreased sensation or loss of function from a stroke or TIA • Diabetes and currently taking more than 50 units of insulin daily, or with peripheral neuropathy, numbness, tingling or decreased sensation in your feet, retinopathy or history of a stroke, ministroke or a TIA • Cancer (except basal or squamous cell skin cancers, or stage I/A bladder, thyroid, breast or prostate cancers) in the past 2 years • Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis and have used tobacco in the past year	☐	☐	☐	☐
5	Have you ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you ever had a screening test in combination with a confirmatory test, both of which detected the presence of HIV antibodies, antigens, or the virus?	☐	☐	☐	☐
6	Are you currently eligible for benefits under, or covered by, Medicaid (not Medicare), disability income, workers' compensation, Social Security disability or any federal or state disability plan?...	☐	☐	☐	☐

Section E PRIMARY CARE PHYSICIAN INFORMATION AND MEDICATION

1 **Provide the name, complete address and phone number of your Primary Care Physician.**

	Applicant A	Applicant B *(If Different than Applicant A)*
Primary Care Physician		
Address		
City, State, ZIP		
Phone Number		
2 Date & Reason for Last Visit:		

3 Are you taking or have you taken any prescription medication(s) within the past 12 months, or are you currently taking any over-the-counter medication(s) on a weekly basis or more frequently?...

If "**Yes**," please list below all the medication name(s) using pharmacy label, dosage/frequency and reason prescribed. (Attach additional signed page(s) if more space is needed.)

Applicant A Yes	Applicant A No	Applicant B Yes	Applicant B No
☐	☐	☐	☐

	Applicant A	Applicant B
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		
Medication Name		
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Disease/Disorder/Condition		
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		
Medication Name		
Dosage/Frequency		
Disease/Disorder/Condition		

Section F ADDITIONAL HEALTH QUESTIONS

		Applicant A		Applicant B	
		Yes	No	Yes	No
1	Do you have, or have you ever received any advice, treatment, consultation or diagnosis from a physician or health care provider for any of the following conditions?				
	Alcohol or Drug Use	☐	☐	☐	☐
	Anemia or Blood Disease/Disorder	☐	☐	☐	☐
	Arthritis, Back, Bone or Joint Disorder or Broken Bones	☐	☐	☐	☐
	Balance Disorder, Difficulty Walking or Falls	☐	☐	☐	☐
	Bowel or Bladder Disease/Disorder	☐	☐	☐	☐
	Cancer	☐	☐	☐	☐
	Circulatory Disease/Disorder	☐	☐	☐	☐
	Depression or other Mental Disorder	☐	☐	☐	☐
	Diabetes	☐	☐	☐	☐
	Dizziness or Fainting	☐	☐	☐	☐
	Fibromyalgia, Weakness or Fatigue	☐	☐	☐	☐
	Heart Disease/Disorder or High Blood Pressure	☐	☐	☐	☐
	Immune System Disease/Disorder	☐	☐	☐	☐
	Kidney or Liver Disease/Disorder	☐	☐	☐	☐
	Neurological Disease/Disorder	☐	☐	☐	☐
	Osteoporosis	☐	☐	☐	☐
	Respiratory Disease/Disorder	☐	☐	☐	☐
	Seizures, Epilepsy or Tremors	☐	☐	☐	☐
	Vision Disorder	☐	☐	☐	☐
2	Have you received inpatient or outpatient treatment at a hospital, surgical center or rehabilitation facility in the past 12 months?	☐	☐	☐	☐
3	Are you scheduled for, or have you been advised by a physician or health care provider to have additional testing, surgery or consultation(s) to evaluate your health?	☐	☐	☐	☐
4	Are there any pending test results which you have not yet received?	☐	☐	☐	☐
5	Have you been seen by your physician, health care provider or any specialist more than three times in the past 12 months?	☐	☐	☐	☐
6	Do you have, for your use, a handicap parking sticker or handicap license plate?	☐	☐	☐	☐
7	Have you used tobacco in any form in the past 2 years?	☐	☐	☐	☐
8	What is your height?	' "		' "	
9	What is your weight?	lbs		lbs	

Section F ADDITIONAL HEALTH QUESTIONS (continued)

If "Yes" to any additional health questions of Section F, please provide the following for each "Yes" answer below.
(Attach additional signed page(s) if more space is needed.)

Applicant A

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

Applicant B

Disease/Disorder/Condition	Date of Occurrence	Date of Last Visit	Physician/Facility Information
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____
			Name _____ Address _____ City, State, ZIP Code _____ Phone # _____

INSTRUCTIONS: Complete Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – OR – Section H for MUTUAL CARE MY WAY.

INFLATION PROTECTION: You have the option to purchase a 5% Compound Inflation Protection (Lifetime) benefit. Neither MUTUAL CARE 3 nor MUTUAL CARE 5 offer the 5% Compound Inflation Protection (Lifetime) benefit. If you want to purchase this benefit – SKIP Section G and complete Section H for MUTUAL CARE MY WAY. Check the first box in H7.

Section G — MUTUAL CARE 3 – OR – MUTUAL CARE 5

Applicant A

1 Select Mutual Care 3 or Mutual Care 5 (must check one):

☐ **Mutual Care 3**
- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

☐ **Mutual Care 5**
- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

2 Acknowledgement (must check):

☐ **I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

3 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐☐ per month
($3,000-$15,000 in $500 increments)

4 Nonforfeiture Benefit – Shortened Benefit Period (must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

Applicant B (If selecting Spouse Shared Care Benefit, benefits must be identical to Applicant A)

1 Select Mutual Care 3 or Mutual Care 5 (must check one):

☐ **Mutual Care 3**
- 3 Year Maximum Lifetime Benefit = 36 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 3% Compound Inflation Protection (Lifetime)

☐ **Mutual Care 5**
- 5 Year Maximum Lifetime Benefit = 60 x Maximum Monthly Benefit (MMB)
- Nursing Home Benefit is up to 100% of the MMB
- Assisted Living Facility Benefit is up to 100% of the MMB
- Home Health Care Benefit is up to 100% of the MMB
- Cash Benefit is 35% of Home Health Care Benefit
- 90 Calendar Day Elimination Period
- 5% Compound Inflation Protection (20 Year)

2 Acknowledgement (must check):

☐ **I acknowledge that by checking this box, the 5% Compound Inflation Protection (Lifetime) is NOT included:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option.

3 Maximum Monthly Benefit (MMB) (must enter):

$ ☐☐,☐☐☐ per month
($3,000-$15,000 in $500 increments)

4 Nonforfeiture Benefit – Shortened Benefit Period (must check "YES" or "NO"):

☐ **YES**

☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

OPTIONAL BENEFIT FOR MUTUAL CARE 3 – OR – MUTUAL CARE 5

5 ☐ **Spouse Shared Care Benefit**
Only available when both Spouses or Domestic Partners apply at the same time and both policies are issued with identical benefits.

If you completed Section G for MUTUAL CARE 3 or MUTUAL CARE 5 – SKIP Section H and continue to Section I.

If MUTUAL CARE 3 or MUTUAL CARE 5 was selected – SKIP Section H.

Section H — MUTUAL CARE MY WAY

If you are customizing your plan – COMPLETE this Section H.

Applicant A	Applicant B (If selecting Spouse Shared Care Benefit, benefits must be identical to Applicant A)
1 Maximum Monthly Benefit (MMB) (must enter): $ ☐☐,☐☐☐ per month **($1,500-$15,000 in $500 increments)**	**1 Maximum Monthly Benefit (MMB)** (must enter): $ ☐☐,☐☐☐ per month **($1,500-$15,000 in $500 increments)**
2 Maximum Lifetime Benefit = number of months selected x MMB (must check one): ☐ 2 Year (24 months) ☐ 3 Year (36 months) ☐ 4 Year (48 months) ☐ 5 Year (60 months) ☐ 6 Year (72 months) ☐ 8 Year (96 months) ☐ Lifetime	**2 Maximum Lifetime Benefit** = number of months selected x MMB (must check one): ☐ 2 Year (24 months) ☐ 3 Year (36 months) ☐ 4 Year (48 months) ☐ 5 Year (60 months) ☐ 6 Year (72 months) ☐ 8 Year (96 months) ☐ Lifetime
3 Assisted Living Facility Benefit as a Percentage of the Maximum Monthly Benefit (must check one): Up to: ☐ 50% ☐ 75% ☐ 100%	**3 Assisted Living Facility Benefit as a Percentage of the Maximum Monthly Benefit** (must check one): Up to: ☐ 50% ☐ 75% ☐ 100%
4 Home Health Care Benefit as a Percentage of the Maximum Monthly Benefit (must check one): Up to: ☐ 50% ☐ 75% ☐ 100%	**4 Home Health Care Benefit as a Percentage of the Maximum Monthly Benefit** (must check one): Up to: ☐ 50% ☐ 75% ☐ 100%
5 ☑ **Cash Benefit – 35% of Home Health Care Benefit** (automatically included)	**5** ☑ **Cash Benefit – 35% of Home Health Care Benefit** (automatically included)
6 Calendar Day Elimination Period (must check one): ☐ 0 Day ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day ☐ 365 Day	**6 Calendar Day Elimination Period** (must check one): ☐ 0 Day ☐ 30 Day ☐ 60 Day ☐ 90 Day ☐ 180 Day ☐ 365 Day
7 Inflation Protection: 5% Compound (Lifetime) (must check "YES" or "NO"): ☐ **YES, I am selecting the 5% Compound Inflation Protection (Lifetime)** ☐ **NO, 5% Compound Inflation Protection (Lifetime) is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option. **If you selected "NO" to the 5% Compound (Lifetime), check one Inflation Option below:** ☐ 5% Simple (Lifetime) ☐ 5% Compound (20 Year) ☐ 4% Compound (Lifetime) ☐ 3% Compound (Lifetime) ☐ No Inflation Protection with Future Purchase Option	**7 Inflation Protection:** 5% Compound (Lifetime) (must check "YES" or "NO"): ☐ **YES, I am selecting the 5% Compound Inflation Protection (Lifetime)** ☐ **NO, 5% Compound Inflation Protection (Lifetime) is NOT desired:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the 5% Compound Inflation Protection (Lifetime) option. Specifically, I have reviewed the option for Compound and Simple Inflation increases, and I reject the 5% Compound Inflation Protection (Lifetime) option. **If you selected "NO" to the 5% Compound (Lifetime), check one Inflation Option below:** ☐ 5% Simple (Lifetime) ☐ 5% Compound (20 Year) ☐ 4% Compound (Lifetime) ☐ 3% Compound (Lifetime) ☐ No Inflation Protection with Future Purchase Option

Section H MUTUAL CARE MY WAY (continued)

Applicant A	Applicant B
8 **Nonforfeiture Benefit – Shortened Benefit Period** (must check "YES" or "NO"): ☐ **YES** ☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.	**8** **Nonforfeiture Benefit – Shortened Benefit Period** (must check "YES" or "NO"): ☐ **YES** ☐ **NO, Nonforfeiture Benefit – Shortened Benefit Period option is NOT desired:** I have reviewed the Outline of Coverage and compared the benefits and premiums of this policy with and without the Nonforfeiture Option(s) that have been made available and I reject the Nonforfeiture Benefit – Shortened Benefit Period option that is available.

OPTIONAL BENEFITS FOR MUTUAL CARE MY WAY

9 ☐ **Waiver of Elimination Period for Home Health Care Benefit**	**9** ☐ **Waiver of Elimination Period for Home Health Care Benefit**
10 **Spousal Benefits:** The **Spouse Waiver of Premium, Spouse Survivorship Benefit** and **Spouse Shared Care Benefit** are only available when both Spouses or Domestic Partners apply at the same time and both policies are issued. ☐ **Spouse Waiver of Premium** ☐ **Spouse Survivorship Benefit** ☐ **Spouse Shared Care Benefit** The **Spouse Shared Care Benefit** is only available when both policies are issued with identical benefits.	**10**
11 ☐ **Spouse Security Benefit** Not available for issue ages 70 and older, with Spousal Benefits or if Spouse or Domestic Partner is applying for this coverage. _____ Spouse's or Domestic Partner's Name	**11**
12 ☐ **Restoration of Benefits** Not available with Lifetime Benefits.	**12** ☐ **Restoration of Benefits** Not available with Lifetime Benefits.
13 ☐ **Additional Benefit for Injury**	**13** ☐ **Additional Benefit for Injury**
14 ☐ **5 Years of Rate Guarantee**	**14** ☐ **5 Years of Rate Guarantee**
15 **Return of Premium at Death Benefit:** ☐ Return of Premium (Less Claims Paid) If Death Occurs Before Age 65 **OR** ☐ Return of Premium at Death (Less Claims Paid) **OR** ☐ Full Return of Premium at Death	**15** **Return of Premium at Death Benefit:** ☐ Return of Premium (Less Claims Paid) If Death Occurs Before Age 65 **OR** ☐ Return of Premium at Death (Less Claims Paid) **OR** ☐ Full Return of Premium at Death

Continue to Section I.

Section I PREMIUM INFORMATION

Applicant A

1 Premium Options (must check one):

☐ Lifetime
☐ Single Premium
☐ 10-Year Pay
☐ 20-Year Pay
☐ To-Age-65

2 Premium Amount:

Modal Premium: $ _____

Premium Collected: $ _____
– Two Months Minimum

3 Recurring Premium Mode (check one unless Single Premium):

☐ Monthly Automatic Checking Account (.09) Deduction

Specify the date premiums will be withdrawn (1st through the 28th of the month): _____

Bank Name _____

Routing Number

Account Number

(Or include a voided check.)

Applicant B

1 Premium Options (must check one):

☐ Lifetime
☐ Single Premium
☐ 10-Year Pay
☐ 20-Year Pay
☐ To-Age-65

2 Premium Amount:

Modal Premium: $ _____

Premium Collected: $ _____
– Two Months Minimum

3 Recurring Premium Mode (check one unless Single Premium):

☐ Monthly Automatic Checking Account (.09) Deduction

Specify the date premiums will be withdrawn (1st through the 28th of the month): _____

Bank Name _____

Routing Number

Account Number

(Or include a voided check.)

Authorization to Withdraw Funds by Mutual of Omaha Insurance Company
I authorize Mutual of Omaha Insurance Company (Mutual of Omaha) to withdraw funds from my account for my initial and/or renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

X _____ _____
Signature of Account Holder Date

X _____ _____
Signature of Account Holder Date

Direct Bill:
☐ Quarterly (.26) ☐ Semiannual (.51) ☐ Annual (1.0)

Billing Address for Premium Notices ***(if different from page 1)***:

Name

Street Address, Apartment Number

City, State, ZIP Code

Direct Bill:
☐ Quarterly (.26) ☐ Semiannual (.51) ☐ Annual (1.0)

Billing Address for Premium Notices ***(if different from page 1)***:

Name

Street Address, Apartment Number

City, State, ZIP Code

4 Select Effective Date:

☐ Date of Application
☐ Date Policy is Issued
☐ For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

4 Select Effective Date:

☐ Date of Application
☐ Date Policy is Issued
☐ For Replacements Only, Requested Effective Date of Coverage _____
(up to 60 days from application date)

Section J NOTICE BEFORE LAPSE OR TERMINATION

Please check the applicable box and complete the requested information. You may want to consider designating someone other than a Spouse or Domestic Partner.

Applicant A	Applicant B
☐ I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium.	☐ I wish to designate an additional person to receive notice of lapse or termination of the policy due to nonpayment of premium. ***(If Different than Applicant A)***
Name (Print full name of other person to receive notice of lapse or termination)	Name (Print full name of other person to receive notice of lapse or termination)
Street Address, Apartment Number	Street Address, Apartment Number
City, State, ZIP Code	City, State, ZIP Code
Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.	Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.
OR	**OR**
☐ I elect NOT to designate any person to receive such notice.	☐ I elect NOT to designate any person to receive such notice.

Section K AGREEMENTS AND ACKNOWLEDGEMENTS

1. The undersigned applicant agrees that (a) all answers in this application are true and complete and Mutual of Omaha Insurance Company will rely on these answers to determine insurability, and (b) incorrect or misleading answers may void this application and any policy issued from its effective date.
2. Applicant acknowledges that Mutual of Omaha Insurance Company may require: an Attending Physician's Statement, medical records, an underwriting assessment, a medical examination, or other information.
3. Except as may be provided in a Temporary Insurance Agreement and Receipt ("TIA"), applicant agrees that Mutual of Omaha Insurance Company will not issue a policy as a result of this application unless (a) the insurance applicant completes all medical examinations and tests required by Mutual of Omaha Insurance Company, (b) Mutual of Omaha Insurance Company receives any additional information requested for underwriting (such as Personal Worksheet, Personal Health Interview, or Attending Physician's Statement), and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance coverage applied for, or the insurance applicant has subsequently accepted an offer by Mutual of Omaha Insurance Company for coverage other than as applied for, according to the underwriting standards of Mutual of Omaha Insurance Company then in force.
4. Coverage will take effect as provided in and subject to the terms of a TIA if an advance payment of premium is made which satisfies the requirements of the TIA. Any coverage under a TIA is subject to the requirements set forth in the TIA, and benefits under a TIA are limited to a period of one (1) year after the date a claim under the TIA begins.
5. Applicant acknowledges that no Producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. Applicant acknowledges receipt of an Outline of Coverage, Shopper's Guide to Long-Term Care Insurance, Potential Rate Increase Disclosure Form and, if applicable, *Guide to Health Insurance for People with Medicare*.

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

Caution: If your answers on this application are incorrect or untrue, Mutual of Omaha Insurance Company has the right to deny benefits or rescind your policy.

I have read and understand this Agreements and Acknowledgements Section, including the Fraud Warning and I approve all my answers as recorded in this application.

Signed at _____ (City) _____ (State)

X _____ (Signature of Applicant A) _____ (Date)

Signed at _____ (City) _____ (State)

X _____ (Signature of Applicant B) _____ (Date)

I/We, the Producer(s) certify that each question was asked exactly as written and I/we have recorded the answers provided by the Applicant(s) completely and accurately. I/We also agree that my/our answers in this application are true and complete.

☐ **Yes** ☐ **No** (If "No," please explain) _____

X _____

Signature of Licensed Producer(s)

Appendix 1 AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION - ARIZONA

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, clearinghouses, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, state department of motor vehicles and other entities possessing motor vehicle records, consumer reporting agencies and all providers of medical or dental services to release personal information about me to Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Personal information includes my health information such as medical history, mental or physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug or alcohol use and other information such as motor vehicle records, finances, occupation, general reputation and insurance claims information. The personal information may include my entire medical record.

The personal information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on the application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my 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.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed, except that disclosure of HIV-related information is authorized for 180 days from the date I sign it. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy. I understand that I or my personal representative will receive a copy of this authorization and that a copy is as valid as the original.

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

Printed Name of Applicant A	Birth State and County	Printed Name of Applicant B	Birth State and County
X _____ Signature of Applicant A	Date	X _____ Signature of Applicant B	Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

MLU26722_AZ

Appendix 2 PRODUCER STATEMENT

	Yes	No
1. I/We certify that the Notice of Information Practices and Investigative Consumer Reports Notice were given to the Applicant(s)	☐	☐
2. I/We certify that each question was asked exactly as written and that I/we recorded the answers completely and accurately in the presence of the Applicant(s)	☐	☐
(If "No," explain) _____		
3. This coverage is written on myself (the Producer) and/or my Spouse or Domestic Partner	☐	☐

	Applicant A	Applicant B
4. Please indicate the Underwriting Risk classification quoted		
Your quote will be noted, however, Underwriting will determine the final risk classification. We suggest quoting Select unless our Underwriting Guide indicates the health condition(s) warrants a substandard rating. Class II cases should be discussed with an underwriter prior to application submission.		
	☐ Preferred	☐ Preferred
	☐ Select	☐ Select
	☐ Class I	☐ Class I
	☐ Class II	☐ Class II
5. To the best of my knowledge, replacement of other insurance (check box) involved in this transaction		
If replacement is involved, I/we shall comply with all state and/or company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.		
	☐ is	☐ is
	☐ is not	☐ is not

X _____ _____
Signature of Producer (Agent of Record) Date

X _____ _____
Signature of Other Producer, if applicable Date

Producer Information (please print clearly)

For Mutual of Omaha Career Producers Only: **01**
Manager Stamp | DSM Stamp | Producer Stamp

For Brokerage Only: Commission Code [ ][ ] 951300 (**Examples:** 8 8, A 2, etc.)
(– Commission code available from your marketing organization.)

Producer's Name _____ (Agent of Record)
Social Security Number _____
Comm. % Share _____
Producer's Phone Number ( ) _____
Producer's Identification Number _____
Producer's E-mail Address _____

Other Producer's Name _____ (If applicable, for Commission Split)
Social Security Number _____
Comm. % Share _____
Producer's Phone Number ( ) _____
Producer's Identification Number _____
Producer's E-mail Address _____

Whom should we contact with questions regarding this application if different than Producer listed above:

Name _____
Name of Office/Corporation _____
Phone Number ( ) _____
Fax Number ( ) _____
E-mail Address _____

SUBMIT TO LTC SERVICE OFFICE

Appendix 3 TEMPORARY INSURANCE AGREEMENT AND RECEIPT ("Agreement")

Initial Premium paid by check Policy form (rider) applied for LTC09

Applicant A	**Applicant B**
In consideration of the application and payment of $_____ by **Applicant A**, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for **Applicant A**, subject to the following conditions and limitations:	In consideration of the application and payment of $_____ by **Applicant B**, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for **Applicant B**, subject to the following conditions and limitations:

Total Premium
$

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK. DO NOT COLLECT PREMIUMS FOR SINGLE PREMIUM CASES.)

Please read this Agreement carefully. It is important to you. The maximum amount of monthly benefits for long-term care under this and all other Temporary Insurance Agreements is LIMITED. The maximum period for which benefits may be paid is LIMITED.

1. **Eligibility Requirements for Temporary Insurance –** No benefits will be payable under this Agreement if there are incorrect, untrue, incomplete or omitted statements or other material misrepresentations of fact in any part of the application, this Agreement, any supplemental applications or amendments or any questionnaire that becomes a part of the application.
   In addition, Mutual of Omaha Insurance Company ("Mutual") will grant temporary insurance to the proposed insured only if:
   (a) At least one month's premium is received on the date of the application;
   (b) The full amount of any check, draft or money order for such premium is honored on its first presentation for payment;
   (c) This Agreement is completed at the same time as the application; and
   (d) The questions in Section D of the application are answered and each is answered "No." **No Producer is authorized to accept any payment with the application if any of the questions in Section D are answered "Yes", or left blank.**
2. **When Temporary Insurance Begins –** The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Applicant(s) live(s), on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed by the Producer(s) and Applicant(s); or
   (c) The date this Agreement is signed by the Producer(s) and Applicant(s).
3. **Temporary Insurance Benefit –** EXCEPT AS LIMITED IN THE NEXT PARAGRAPH MUTUAL'S LIABILITY IS GOVERNED BY THE TERMS AND CONDITIONS OF THE POLICY(IES) APPLIED FOR. Coverage under this Agreement will be subject to the same terms and conditions as would apply under the policy(ies) applied for.
   No matter how much insurance you applied for or how much of an advance payment you made, the following limitations apply to the coverage under this Agreement:
   (a) The Maximum Monthly Benefit is LIMITED TO THE LESSER OF $3,000 per month or the amount of Maximum Monthly Benefit for long-term care for which you applied.
   (b) Benefits will not start UNTIL you are unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity.
   (c) The maximum amount of benefits paid under this Agreement is LIMITED TO twelve times the amount of Maximum Monthly Benefit as specified in Subsection (a), above.

No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.

In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.

4. **When Temporary Insurance Ends –** The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Applicant(s) live(s), on the earliest of the following dates:
   (a) 60 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy applied for; or
   (c) The date a policy, other than as applied for, is offered by a Producer to the Applicant(s); or
   (d) The date Mutual mails the premium refund and letter informing the Applicant(s) that the policy applied for will not be issued; or
   (e) The date Mutual mails notice of termination of this Agreement to the Applicant(s).

This Agreement does not limit Mutual in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of the Applicant(s) is rejected by Mutual, the amount paid with the application for that Applicant will be refunded to the Applicant(s) regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I/We, the undersigned Proposed Insured(s), have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed at _____ City _____ State	Signed at _____ City _____ State
X _____ Signature of Applicant A _____ Date	X _____ Signature of Applicant B _____ Date

X _____
Signature of Licensed Producer(s)

Long-Term Care Insurance

Notice to Applicant Regarding Replacement of Individual Health or Long-Term Care Insurance

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

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

According to your application, you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 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, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

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 in payment of 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 are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. 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.

X
Signature of Producer

Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X
Signature of Applicant A — Date

X
Signature of Applicant B — Date

Submit to LTC Service Office

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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 notifications on the following pages are to be left with applicant(s) if applicable.

Required Forms to be Left with Applicant(s)				
Replacement Notice *(if applicable)*	Temporary Insurance Agreement and Receipt *(applicable if check received with app)*	MIB Inc. Pre-Notice, Company Notice of Information Practices, Investigative Consumer Reports Notice		
Long-Term Care Insurance Potential Rate Increase Disclosure Form	Things You Should Know Before You Buy Long-Term Care Insurance		Partnership Notice	Outline of Coverage

Not Contained within this Application Package:

Required Forms to be Left with Applicant(s) that are Not Included within this Package	
LTC Shopper's Guide *(Not included within this package. Please provide in addition.)*	Guide to Medicare for People Age 65 and Older *(Not included within this package. If applicable, please provide in addition.)*

Long-Term Care Insurance

Notice to Applicant Regarding Replacement of Individual Health or Long-Term Care Insurance

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

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

According to your application, you intend to lapse or otherwise terminate existing health or long-term care insurance and replace it with an individual long-term care policy to be issued by Mutual of Omaha Insurance Company. Your new policy provides 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, comparing it with all health or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement to Applicant by Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

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 in payment of 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 are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. 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.

X
Signature of Producer

Printed Name and Address of Producer

The above Notice to Applicant was delivered to me on:

X
Signature of Applicant A — Date

X
Signature of Applicant B — Date

Leave this page with Applicant(s)

TEMPORARY INSURANCE AGREEMENT AND RECEIPT ("Agreement")

Initial Premium paid by check Policy form (rider) applied for LTC09

Applicant A

In consideration of the application and payment of $_____ by **Applicant A**, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for **Applicant A**, subject to the following conditions and limitations:

Applicant B

In consideration of the application and payment of $_____ by **Applicant B**, receipt of which is hereby acknowledged, Mutual of Omaha Insurance Company agrees to provide limited temporary long-term care insurance for **Applicant B**, subject to the following conditions and limitations:

Total Premium
$

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA"). ONE CHECK IS ACCEPTABLE FOR JOINT APPLICANTS. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK. DO NOT COLLECT PREMIUMS FOR SINGLE PREMIUM CASES.)

Please read this Agreement carefully. It is important to you. The maximum amount of monthly benefits for long-term care under this and all other Temporary Insurance Agreements is LIMITED. The maximum period for which benefits may be paid is LIMITED.

1. **Eligibility Requirements for Temporary Insurance –** No benefits will be payable under this Agreement if there are incorrect, untrue, incomplete or omitted statements or other material misrepresentations of fact in any part of the application, this Agreement, any supplemental applications or amendments or any questionnaire that becomes a part of the application.
   In addition, Mutual of Omaha Insurance Company ("Mutual") will grant temporary insurance to the proposed insured only if:
   (a) At least one month's premium is received on the date of the application;
   (b) The full amount of any check, draft or money order for such premium is honored on its first presentation for payment;
   (c) This Agreement is completed at the same time as the application; and
   (d) The questions in Section D of the application are answered and each is answered "No." **No Producer is authorized to accept any payment with the application if any of the questions in Section D are answered "Yes", or left blank.**
2. **When Temporary Insurance Begins –** The temporary insurance provided by this Agreement will begin at 12:01 a.m., where the Applicant(s) live(s), on the latest of these dates:
   (a) The date the above sum is received; or
   (b) The date the application is signed by the Producer(s) and Applicant(s); or
   (c) The date this Agreement is signed by the Producer(s) and Applicant(s).
3. **Temporary Insurance Benefit –** EXCEPT AS LIMITED IN THE NEXT PARAGRAPH MUTUAL'S LIABILITY IS GOVERNED BY THE TERMS AND CONDITIONS OF THE POLICY(IES) APPLIED FOR. Coverage under this Agreement will be subject to the same terms and conditions as would apply under the policy(ies) applied for.
   No matter how much insurance you applied for or how much of an advance payment you made, the following limitations apply to the coverage under this Agreement:
   (a) The Maximum Monthly Benefit is LIMITED TO THE LESSER OF $3,000 per month or the amount of Maximum Monthly Benefit for long-term care for which you applied.
   (b) Benefits will not start UNTIL you are unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity.
   (c) The maximum amount of benefits paid under this Agreement is LIMITED TO twelve times the amount of Maximum Monthly Benefit as specified in Subsection (a), above.

No insurance exists under this Agreement for any health conditions for which there was diagnosis, treatment or consultation within one year prior to the date this Agreement begins.

In no event will benefits be paid for the same loss under both this Agreement and any policy issued from the application.

4. **When Temporary Insurance Ends –** The temporary insurance provided by this Agreement will **automatically terminate** at 12:01 a.m., where the Applicant(s) live(s), on the earliest of the following dates:
   (a) 60 days from the date of this Agreement; or
   (b) The date that insurance takes effect under the policy applied for; or
   (c) The date a policy, other than as applied for, is offered by a Producer to the Applicant(s); or
   (d) The date Mutual mails the premium refund and letter informing the Applicant(s) that the policy applied for will not be issued; or
   (e) The date Mutual mails notice of termination of this Agreement to the Applicant(s).

This Agreement does not limit Mutual in applying its underwriting standards to the application, nor does the Agreement limit or waive any rights under any policy issued. If the application of the Applicant(s) is rejected by Mutual, the amount paid with the application for that Applicant will be refunded to the Applicant(s) regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer(s).

I/We, the undersigned Proposed Insured(s), have read and received a copy of this Agreement and understand and agree to all of its terms.

Signed at _____ City _____ State

X _____ Signature of Applicant A _____ Date

Signed at _____ City _____ State

X _____ Signature of Applicant B _____ Date

X _____ Signature of Licensed Producer(s)

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Mutual of Omaha Insurance Company, 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 Insurance Company, 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

COMPANY NOTICE OF INFORMATION PRACTICES

In accordance with Arizona Insurance Laws, Mutual of Omaha Insurance Company is required to disclose certain information about our insurance information practices in connection with transactions relating to your coverage.

1. Personal information may be collected from persons other than you.
2. The information, as well as other personal or privileged information subsequently collected by Mutual of Omaha Insurance Company or its agent(s), may in certain circumstances be disclosed to third parties without your specific authorization.
3. You are entitled to access any and all personal information collected and to correct such information if it is found to be in error.
4. Upon your request, Mutual of Omaha Insurance Company will provide you with more detailed information concerning its information practices, including but not limited to:

    - The types of information that may be collected and the types of sources and investigative techniques that may be used to collect such information; and
    - The types of disclosures of information that Mutual of Omaha Insurance Company is permitted to make and the circumstances in which such disclosures may be made without prior authorization.

M24237

INVESTIGATIVE CONSUMER REPORTS NOTICE

Mutual of Omaha Insurance Company ("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.

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

This is not applicable to single premium.

1. **Premium Rate**: Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is: Applicant A $ _____ Applicant B $ _____
2. **The premium for this policy will be shown on the schedule page of your policy.**
3. **Rate Schedule Adjustments:**

   The premium rates for this policy may change. Any change will be effective on the next billing date after the company has provided you at least 60 days written notice before we change premiums.
4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the greater of the total amount of premiums you've paid since your policy was first issued or the maximum monthly benefit. If you have already received benefits under the policy, so that the remaining lifetime maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Leave this page with Applicant(s)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers of Substantial Premium Increase

Issue Age	% Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The maximum monthly benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the maximum monthly benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

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Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. This is not applicable to single premium.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities

Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

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Regulatory Bulletin 2009-05
Attachment B

STATE OF ARIZONA
LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM
PRE-PURCHASE NOTICE
IMPORTANT NOTICE FOR ARIZONA RESIDENTS
WHO ARE THINKING OF BUYING LONG-TERM CARE INSURANCE

Insurance Company Name: _____
Producer's Name: _____
Address: _____
Phone Number: _____
Email Address: _____

Long-Term Care Partnership Policies

The State of Arizona has implemented a Long-Term Care Insurance Partnership Program (the "Partnership Program") that constitutes a partnership between state government and private insurance companies to assist Arizona residents in planning their long-term care needs. Insurance companies voluntarily participate in the Partnership Program by offering long-term care insurance policies ("Partnership Policies") that meet special federal requirements.

If you purchase a Partnership Policy and later apply for long-term care coverage from Arizona's Medicaid program, your application will include a Medicaid eligibility feature known as "Asset Disregard". "Asset Disregard" means that Medicaid will disregard some of your assets in determining whether you are eligible for Medicaid long term care coverage. The amount of assets that Medicaid can disregard will be equal to amount of long-term care insurance benefits you have received under your Partnership Policy. If you are thinking of buying a long-term care insurance policy, you should carefully consider whether Asset Disregard is important to you, and whether your long-term care insurance policy should be a Partnership Policy.

Three important things to know about Partnership Policies

1. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.** Medicaid has other eligibility criteria that may disqualify you. In addition, the Asset Disregard rules may not apply to you if your home equity exceeds $500,000.

2. **Asset Disregard is only available under a Partnership Policy** and not every long-term care policy is a Partnership Policy.

3. **It is possible that a Partnership Policy will lose its Partnership status in the future if**:
    a. You make a change to a Partnership Policy, including a change to the inflation protection provisions, if any.
    b. You move to a state that does not have a Partnership Program.
    c. There is a change to state or federal law that governs the Partnership Program.

Additional Information

If you have questions about buying a long-term care insurance policy please contact the insurer. If you have questions regarding current laws governing Medicaid eligibility, please contact the Arizona Health Care Cost Containment System ("AHCCCS").

MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175, **1-877-894-2478**

LONG-TERM CARE INSURANCE - OUTLINE OF COVERAGE

For Long-Term Care Insurance Form LTC09M

Tax-Qualified

NOTICE TO BUYER: The policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

CAUTION: The issuance of the long-term care insurance policy is based upon the responses to questions on your application. A copy of your application will be attached to your policy if one is issued to you. If your answers are incorrect or untrue, we have the right to deny benefits or rescind the policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at this address: Mutual of Omaha Insurance Company, Long-Term Care Service Office, P.O. Box 64901, St Paul, MN 55164-0901.

1. POLICY DESIGNATION

This is an individual policy of insurance to be issued in the state of Arizona.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the individual or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be federally tax-qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

Renewability

THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right to continue the policy in force for as long as you live or until the maximum lifetime benefit is exhausted. Subject to the terms of the policy, we cannot cancel your coverage as long as you pay the required premium when it is due. Mutual of Omaha Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium

We will waive the payment of premium for the policy if you are receiving Nursing Home Benefits, Assisted Living Facility Benefits or Home Health Care Benefits for, in any month, at least eight days of Home Health Care or Adult Day Care. We will waive premium so long as such benefits are payable. The Elimination Period must be satisfied before we will waive the payment of premium for this policy. Any premium paid for a period for which premiums have been waived will be credited towards future premium payments. When the waiver period ends, premium payments will resume for this policy and must be paid to keep the policy in force.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

We reserve the right to increase the premium for this policy, but never more than once per year. However, any change in premium must apply to all policies issued to persons of the same Policy Class. That means, except when required by a change in benefits under the policy, premium will not increase due to a change in your age or health or your use of the long-term care coverage. We must give you at least 60 days written notice before we change premium. We will not increase the premium for this policy before the Rate Guarantee Period, if any, shown in the Policy Schedule has expired, except when required by a change in benefits under the policy.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

a) You may cancel your policy for any reason within 30 days after you receive it. To do so, mail or deliver the policy to either us or to the agent or office through which it was purchased. We will refund the full amount of any premium paid within 30 days of such a policy return: and the policy will be considered never to have been issued.

b) The policy contains a provision for the return of unearned premium in the event of termination due to death. Upon receipt of notice that you cancelled your policy or that you have died, we will refund the portion of the premium paid for the period between the date of cancellation or death and the next premium due date. We will pay the refund to you or, upon your death, your spouse, if living, or to your estate.

c) The optional Full Return of Premium at Death Benefit provides for a refund of premiums upon your death. If the company receives proof of your death occurring while your coverage was in force, the total amount of premiums paid for your coverage, from the effective date of the Full Return of Premium at Death Benefit coverage up to the date of your death may be refunded without interest.

The optional Return of Premium at Death Less Claims Benefit provides for a refund of premiums if you die while the policy is in force, less the amount of claims paid under the policy. We will not add interest to the benefit paid under this benefit.

The optional Return of Premium (Less Claims Paid) if Death Occurs Before Age 65 Benefit provides for a refund of premiums if you die while the policy is in force but prior to the policy anniversary date coinciding with or next following your 65th birthday. We will not add interest to the benefit paid under this benefit.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from Mutual of Omaha Insurance Company. Neither Mutual of Omaha Insurance Company nor its agents represent Medicare, the federal government, or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the Home. This policy reimburses you for expenses you incur for covered long-term care expenses.

9. BENEFITS PROVIDED BY THE POLICY

Benefits

Benefits are available up to the monthly and lifetime maximum until the applicable maximum lifetime benefit has been reduced to zero. Refer to your completed application for the level of coverage and features selected.

Care Coordination

We will pay the eligible expenses made by a Care Coordinator for the following services: (a) assessing your need for long-term care services; (b) developing your Plan of Care; (c) coordinating the delivery of long-term care services; and (d) if you desire, monitoring the delivery of such long-term care services.

Except for Stay-at-Home Benefits and Alternate Care Benefits, you are not required to use a Care Coordinator to receive benefits under the policy. While a Care Coordinator will assist you in identifying qualified providers, you are responsible for choosing your long-term care providers. You are not required to use the providers identified in any Plan of Care developed by a Care Coordinator. You do not need to satisfy the Elimination Period to receive the services of a Care Coordinator. The eligible expenses made by a Care Coordinator will not reduce your maximum lifetime benefit.

Facility Assessment

We will pay the eligible expenses made by a Care Coordinator to assess the safety and adequacy of the facility in which you are receiving long-term care. The Care Coordinator must provide you or your representative with a written report of such facility assessment. We will pay for such assessment no more than once per calendar year.

Nursing Home Benefit

We will pay a Nursing Home Benefit if you are confined to a Nursing Home. The Nursing Home Benefit is equal to the eligible expenses made by a Nursing Home each month, up to the Nursing Home maximum monthly benefit. Eligible expenses payable under the Nursing Home Benefit are limited to: (a) room and board; (b) Ancillary Services; and (c) patient supplies provided by the Nursing Home for care of its residents.

Eligible expenses do not include Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; transportation; items and services furnished at your request for comfort, convenience or entertainment, such as televisions, telephones and beauty care; or guest meals or spouse charges.

Nursing Home Bed Reservation Benefit
If you are confined to a Nursing Home and absent for any reason other than discharge, we will continue to pay the Nursing Home Benefit as if you were still confined. This Nursing Home Bed Reservation Benefit will be paid only if you have incurred a charge to reserve your place at the Nursing Home. No additional Nursing Home Bed Reservation Benefits are payable in any calendar year once we have paid Nursing Home Bed Reservation Benefits for the maximum number of days (up to 30 days in a calendar year.) Any unused days cannot be carried over into the next calendar year.

Assisted Living Facility Benefit
We will pay an Assisted Living Facility Benefit if you are confined to an Assisted Living Facility. The Assisted Living Facility Benefit is equal to the eligible expenses made by an Assisted Living Facility each month, up to the Assisted Living Facility maximum monthly benefit. Eligible expenses payable under the Assisted Living Facility Benefit are limited to: (a) room and board for a one-bedroom unit; (b) Ancillary Services; and (c) patient supplies provided by the Assisted Living Facility for care of its residents.

Eligible expenses do not include Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; transportation; items and services furnished at your request for comfort, convenience or entertainment, such as televisions, telephones and beauty care; or guest meals or spouse charges.

Assisted Living Facility Bed Reservation Benefit
If you are confined to an Assisted Living Facility and absent for any reason other than discharge, we will continue to pay the Assisted Living Facility Bed Reservation as if you were still confined. This Assisted Living Facility Bed Reservation benefit will be paid only if you have incurred a charge to reserve your place at the Assisted Living Facility. No additional Assisted Living Facility Bed Reservation Benefits are payable in any calendar year once we have paid Assisted Living Facility Bed Reservation Benefits for the maximum number of days (up to 30 days in a calendar year.) Any unused days cannot be carried over into the next calendar year.

Home Health Care Benefit
We will pay a Home Health Care benefit if you receive Home Health Care or Adult Day Care. The Home Health Care Benefit is equal to the eligible expenses incurred by you for Home Health Care or Adult Day Care each month, up to the Home Health Care maximum monthly benefit amount selected. To be eligible for Home Health Care Benefits, eligible expenses incurred by you for Home Health Care must be provided by a Home Health Care Agency or independent provider and for Adult Day Care must be provided by an Adult Day Care Center. Home Health Care Benefits include eligible expenses incurred by you for transportation to and from an Adult Day Care Center.

Respite Care Benefit
In order to provide temporary relief to an unpaid caregiver, you may receive Respite Care during a temporary stay in a Nursing Home or Assisted Living Facility or in your Home or an Adult Day Care Center. When you receive Respite Care, we will pay the eligible charges made by a Nursing Home or Assisted Living Facility or incurred by you for Home Health Care or Adult Day Care each month, up to the Respite Care maximum monthly benefit. Respite Care Benefits will be paid for no longer than the period of time selected and shown in your policy schedule. You do not need to satisfy the Elimination Period to receive Respite Care Benefits.

Hospice Care Benefit
If you are terminally ill, you may receive Hospice Care during a confinement to a Nursing Home or Assisted Living Facility or in your Home or Adult Day Care Center. When you receive Hospice Care, we will pay Nursing Home benefits, Assisted Living Facility benefits and Home Health Care benefits, without requiring you to satisfy the Elimination Period. No additional Hospice Care benefits are payable if your Physician ceases to certify you as terminally ill.

International Benefit
We will pay an International Benefit if you are confined to a Nursing Home or Assisted Living Facility or receive Home Health Care or Adult Day Care outside of the United States, its possessions or territories, Canada or the United Kingdom. The International Benefit is equal to the maximum monthly benefit selected by you. The International Benefit is paid each month you are eligible to receive the International Benefit. The International Benefit will be paid regardless of whether eligible expenses incurred by you in any month are more or less than the maximum monthly benefit. No additional International Benefits are payable under this policy once we have paid International Benefits equal to the International Benefit Lifetime Maximum. All payments of International Benefits will be made in U.S. dollars.

Stay-At-Home Benefits (Available when you use a Care Coordinator) *
We will pay the eligible expenses for Stay-at-Home Benefits if recommended by a Care Coordinator. Except for the Caregiver Training Benefit, the Care Coordinator must determine that the Stay-at-Home Benefit is a cost effective alternative to benefits otherwise provided by the policy. We will not pay eligible expenses incurred prior to the date the Care Coordinator makes such determination.

You can receive Stay-at-Home Benefits at the same time you receive other benefits under the policy. No further Stay-at-Home Benefits will be paid once we have paid Stay-At-Home Benefits in an amount equal to the Stay-At-Home Lifetime Maximum. (These benefits combined are payable up to two times the Basic/Professional/Home Health Care maximum monthly benefit.) You do not need to satisfy the Elimination Period to receive Stay-at-Home Benefits.

**** Caregiver Training Benefit***
We will pay the eligible expenses for training a Family Member or friend to provide care for you in your Home. To be eligible for this benefit, the training must cover the proper use and care of a therapeutic device or an appropriate care giving procedure by a trainer approved by us. We will not pay to train someone who will be paid to care for you. The training can be received while you are confined in a hospital, Assisted Living Facility or Nursing Home only if it is reasonably expected that such training will make it possible for you to return Home where you can be cared for by the person receiving the training.

**** Durable Medical Equipment Benefit***
We will pay the eligible expenses for Durable Medical Equipment. Eligible expenses payable under the Durable Medical Equipment Benefit are limited to the purchase price of the Durable Medical Equipment or, if such Durable Medical Equipment is normally rented on a periodic basis, the rental charge. The decision whether to purchase as opposed to rent Durable Medical Equipment will be made by us at our sole discretion.

**** Home Modification Benefit***
We will pay the eligible expenses for modifications to your Home which are intended to enhance your ability to perform the Activities of Daily Living and/or allow you to remain in your Home safely. Eligible expenses payable under the Home Modification Benefit are limited to the expenses incurred by you for labor, equipment, and supplies. The Home Modification Benefit may not be used solely to increase the value of your Home.

**** Medical Alert System Benefit***
We will pay the eligible expenses for a Medical Alert System to be installed in your Home. Eligible expenses payable under the Medical Alert System Benefit are limited to the installation and rental charges for a Medical Alert System.

Alternate Care Benefit (Available when you use a Care Coordinator)
We may, at our sole discretion, pay an Alternate Care Benefit. An Alternate Care Benefit will be paid if you receive an alternative type of care, treatment, service or supply for which benefits are not payable under the policy. The amount of any Alternate Care Benefit will be determined by us at time we approve such care. To be eligible for Alternate Care Benefits, a Care Coordinator must recommend the alternative type of care, treatment, service or supply. The Care Coordinator, your Licensed Health Care Practitioner, you or your representative and we must all agree that the alternative type of care appropriately meets your needs and is a cost-saving alternative to other benefits provided by the policy.

At the time we approved such care, we will determine whether you must satisfy the Elimination Period to receive Alternate Care Benefits. Upon written notice to you or your representative, we may, at our discretion, discontinue paying you Alternate Care Benefits without affecting your rights to other benefits provided by the policy.

Cash Benefit
Payment of Cash Benefits
We will pay a Cash Benefit each month you are Chronically Ill, if you elect this benefit at the time of claim. The amount of the Cash Benefit to be paid each month is the amount you select and shown in the policy schedule.

A Cash Benefit will be paid in advance each month you are eligible for a Cash Benefit. If we determine you are eligible for a Cash Benefit for less than an entire month, we will adjust the Cash Benefit for that month. The Cash Benefit will be prorated based on the actual number of days you are eligible for a Cash Benefit in such month. We will assume that such month consists of 30 days regardless of the actual number of days in such month. If in any month you receive a Cash Benefit in excess of the amount for which you are eligible, we will reduce any future benefits paid to you under the policy by the amount of the unearned Cash Benefit.

Effect of Receiving Cash Benefits
While you are receiving Cash Benefits, no other benefits are payable under the policy. You may elect to discontinue receiving Cash Benefits by providing written notice to us. After Cash Benefits have been discontinued, you may receive any other benefit offered under the policy for which you are eligible. If you later decide not to receive other benefits under the policy, you may again elect to receive Cash Benefits.

Other Information
You do not need to satisfy the Elimination Period to receive Cash Benefits. We reserve the right to require you to submit a new Plan of Care at least once every 60 days while you are receiving Cash Benefits.

Additional Benefit for Injury
If you elect this option: You are eligible for an Additional Benefit for Injury if, prior to the policy anniversary date coinciding with or next following your 65th birthday, you sustain an injury which results in your confinement to a Nursing Home or Assisted Living Facility or receiving Home Health Care Benefits. You must sustain such injury while the policy is in force, but when you are not Chronically Ill.

To confirm your eligibility, you must undergo an assessment within 90 days of sustaining any accident or trauma. Based on such assessment, a Licensed Health Care Practitioner must certify that you sustained an injury. You will no longer be eligible for the Additional Benefit for Injury if a Licensed Health Care Practitioner determines that you are no longer Chronically Ill or you are Chronically Ill for reasons other than your injury.

We will pay an Additional Benefit for Injury any month you incur eligible expenses in excess of the Nursing Home Benefits, Assisted Living Facility Benefits or Home Health Care Benefits paid to you that month.

OPTIONAL BENEFITS
You may elect any of the following options to expand the benefits under the policy:

Waiver of Elimination Period for Home Health Care Benefit
If elected, you do not need to satisfy the Elimination Period to receive Home Health Care Benefits under the policy.

Restoration of Benefits
If benefits have been paid under the policy and you later become eligible for Restoration of Benefits, we will restore your maximum lifetime benefit. Except for any benefits paid for your spouse under any Spouse Shared Care Benefit to the policy, the maximum lifetime benefit will be restored to the amount that would have applied if no benefits had been paid under the policy. To be eligible for Restoration of Benefits, a Licensed Health Care Practitioner must certify that you meet the following requirements for a period of 180 consecutive days: (a) the ability to perform, without Substantial Assistance from another individual, all Activities of Daily Living; and (b) no need for Substantial Supervision by another person to protect yourself from threats to health and safety due to Severe Cognitive Impairment; and (c) no Physician or Licensed Health Care Practitioner has informed you that you require long-term care services. The maximum lifetime benefit will be restored only once during the term of the policy.

Spouse Security Benefit
We will pay a Spouse Security Benefit if you receive other benefits under the policy. However, we will not pay a Spouse Security Benefit if you receive benefits under any Cash Benefit rider attached to the policy. The Spouse Security Benefit is equal to the other policy benefits received by you each month times 60%. Spouse Security Benefits will not reduce the maximum lifetime benefit.

Spouse Waiver of Premium Benefit
You are eligible for this benefit, if both you and your spouse are covered under a separate in force Mutual of Omaha Insurance Company Long-Term Care Insurance policy (Form LTC09M), with a Spouse Waiver of Premium rider.

We will waive the payment of your premium for the policy when and so long as the premium for your spouse's policy is waived under the terms of his or her policy. When the waiver period under your spouse's policy ends, premium payments will resume for your policy and must be paid to keep your policy in force.

An increase in the premium paid by you for the policy may occur as result of your adding or increasing a policy benefit following the policy effective date. We will waive the increased amount of the premium when and so long as the premium for your spouse’s policy is waived under the terms of his or her policy, but only after the expiration of the Qualification Period (10 years).

Spouse Survivorship Benefit
This benefit is applicable only if both you and your spouse are covered under policy (Form LTC09M) Long-Term Care Insurance Policies with this benefit, and you and your spouse are living on the date the Survivorship Benefit has been in force for the length of the Qualification Period (10 years), and both policies are in force. If your spouse dies on or after the date the Survivorship Benefit has been in force for the length of the Qualification Period, your policy will become paid up effective on its next policy renewal date and will continue in force without further premium payments for the rest of your lifetime. The premium for any benefit added or increased after the death of your spouse will not be paid up.

Spouse Shared Care Benefit
If both you and your spouse are each covered under an identical separate in force Mutual of Omaha Insurance Company's Long-Term Care policy (Form LTC09M), you may draw from your spouse's maximum lifetime benefit to pay benefits under your policy. Benefits will be paid in accordance with the terms and conditions in effect under your policy at the time your maximum lifetime benefit was reduced to zero. The maximum lifetime benefit under your spouse's policy will be reduced to the extent that you draw against it to pay benefits under your policy.

Christian Science Providers
If you are eligible to receive Alternate Care Benefits, we may, at our discretion, pay an Alternate Care Benefit for services: (a) provided by an accredited Christian Science Nurse listed in the Christian Science Journal; and (b) incurred while confined in a Christian Science nursing organization/facility currently recognized by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., or any comparable accrediting organization.

LIMITED PREMIUM PAYMENT OPTIONS

You may elect any of the following options to pay the premiums for your policy within a limited time period:

Single Premium Payment Option
If you select this option, that means you paid a single premium for the policy. You will be required to make no further premium payments to keep the policy in force.

10-Year Premium Payment Option
If you select this option, you will pay premium for the policy for 10 policy years. Except as otherwise provided in the rider, from and after the 11th policy anniversary date, you will be required to make no further premium payments to keep the policy in force. From and after the 11th policy anniversary date, you will not be eligible for any refund under the Refund of Unearned Premiums provision of the policy.

If an increase in premium for the policy occurs as a result of your adding or increasing a policy benefit, you will pay the amount of the increase in premium for 10 Policy Years. Thereafter, you will be required to make no further premium payments to keep the policy in force.

20-Year Premium Payment Option
If you select this option, you will pay premium for the policy for 20 policy years. Except as otherwise provided in the rider, from and after the 21st policy anniversary date, you will be required to make no further premium payments to keep the policy in force. From and after the 21st policy anniversary date, you will not be eligible for any refund under the Refund of Unearned Premiums provision of the policy.

If an increase in premium for the policy occurs as a result of your adding or increasing a policy benefit, you will pay the amount of the increase in premium for 20 Policy Years. Thereafter, you will be required to make no further premium payments to keep the policy in force.

To-Age-65 Premium Payment Option
If you select this option, you will pay premium for the policy until the Paid Up Premium Date. (**Paid Up Premium Date** means the policy anniversary date coinciding with or next following your 65th birthday.) Except as otherwise provided in this rider, from and after the Paid Up Premium Date, you will be required to make no further premium payments to keep the policy in force. From and after the Paid Up Premium Date, you will not be eligible for any refund under the Refund of Unearned Premiums provision of the policy.

If an increase to the premium paid by you for the policy occurs as a result of your adding or increasing a policy benefit, you will pay the amount of the increase in premium until the policy anniversary date next following the Paid Up Premium Date. Thereafter, you will be required to make no further premium payments to keep the policy in force.

OPTIONAL NONFORFEITURE BENEFITS

Nonforfeiture Benefit – Shortened Benefit Period
If you elect the optional Nonforfeiture Benefit – Shortened Benefit Period, your coverage will be extended as a Nonforfeiture Benefit, if your policy lapses due to non-payment of premium. However, the Non-forfeiture Benefit will NOT take effect if your policy lapses before the third policy anniversary date.

Under the Nonforfeiture Benefit – Shortened Benefit Period, we will pay benefits under the policy in the amounts and in accordance with the terms of the policy on the date the policy lapsed. However, the maximum lifetime benefit will be

reduced resulting in your benefits being paid for a shorter length of time. The maximum lifetime benefit will be reduced to an amount equal to the greater of:

(a) the maximum monthly benefit in effect on the date the policy lapsed; or
(b) the total amount premiums paid for your policy.

The total of all benefits paid under the policy will not exceed the maximum lifetime benefit that would have been paid if your policy did not lapse.

Contingent Nonforfeiture Benefit

You will receive coverage under this benefit if you do not elect the Nonforfeiture Benefit--Shortened Benefit Period.

Notice of Substantial Premium Increase

We will notify you of any increase in premium for your policy which constitutes a Substantial Premium Increase at least 60 days prior to the date your premium will change. The notice will include the amount of the premium and will offer you the following options:

(a) You may reduce benefits under your policy to the level you can obtain for the premium in effect prior to the increase, without undergoing additional underwriting; or
(b) You may elect to receive the Contingent Nonforfeiture Benefit. You have 120 days following the premium due date to make this election. If your policy lapses during the 120 days following the premium due date, you will be deemed to have made the election to receive this benefit.

If you are also eligible for the Limited Premium Payment Contingent Nonforfeiture Benefit, you must choose between receiving either that benefit or the Contingent Nonforfeiture Benefit. You may not elect to receive both benefits.

Contingent Nonforfeiture Benefit

Under the Contingent Nonforfeiture Benefit, we will pay benefits under the policy in the amounts and in accordance with the terms of the policy on the date the policy lapsed. However, the maximum lifetime benefit will be reduced resulting in your benefits being paid for a shorter length of time. The maximum lifetime benefit will be reduced to an amount equal to the greater of:

(a) the maximum monthly benefit in effect on the date the policy lapsed; or
(b) the total amount premiums paid for your policy.

The total of all benefits paid under the policy will not exceed the maximum lifetime benefit that would have been paid if your policy did not lapse.

Please refer to the Potential Rate Increase Disclosure Form to determine whether or not a change in premiums constitutes a Substantial Premium Increase. Substantial Premium Increase means a cumulative increase to your annual premium that is equal to or exceeds the percentage of your initial annual premium as shown in the Potential Rate Increase Disclosure Form and based on your issue age.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

You are eligible for benefits under the policy if you are Chronically Ill. You are Chronically Ill if, within the preceding twelve month period, a Licensed Health Care Practitioner certifies that: (a) You are unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or (b) You require Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

DEFINITIONS

Activities of Daily Living means the following self-care functions:

Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

Adult Day Care means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center means a facility that is licensed or certified to provide Adult Day Care by the state in which it operates. If the state does not license or certify such facilities, then it must meet all of the following standards:

(a) it provides Adult Day Care in a protective setting and under appropriate supervision;
(b) it operates on less than a 24-hour basis;
(c) it keeps a written record of services for each person; and
(d) it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Alzheimer's Facility means a specialized facility that is engaged primarily in providing care for persons with Alzheimer's disease or other Severe Cognitive Impairment and has the appropriate state licensure, certification or registration to operate as an Alzheimer's Facility.

Ancillary Services means physical, occupational, speech, and respiratory therapies, wound care, medication management, continence care support and similar care-related services or supplies that support Activities of Daily Living.

Assisted Living Facility means a facility or distinctly separate part of a facility that is engaged primarily in providing non-skilled long term care. If required by the state in which it is located, an Assisted Living Facility must have the appropriate state licensure, certification or registration to operate as an Assisted Living Facility.

If the state in which it is located does not require an Assisted Living Facility to be licensed, certified or registered, the facility must meet the following requirements:

(a) provides services and care on a continuous 24-hour basis for persons requiring Substantial Assistance with the Activities of Daily Living or Substantial Supervision due to Severe Cognitive Impairment;
(b) maintains trained staff on duty at all times to provide the services and care;
(c) provides at least three meals a day and accommodates special dietary needs;
(d) provides residential services and Maintenance or Personal Care Services in one location;
(e) maintains formal arrangements with a Physician or nurse to furnish medical care in case of an emergency; and
(f) maintains appropriate procedures to provide onsite assistance with prescription medications.

An Alzheimer's Facility or a Hospice Care Facility may be an Assisted Living Facility if such facility meets the requirements contained in this definition for an Assisted Living Facility located in a state which does not require licensure, certification or registration.

Assisted Living Facility does not include a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or mental or nervous disorder; a Nursing Home; a domiciliary care facility; or your primary place of residence in an area used principally for independent residential living; or a similar establishment.

Care Coordinator means a Licensed Health Care Practitioner who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill. The care coordinator may provide services independent of, or be employed by or under contract to, an agency. Such care coordinator and/or agency must be designated by us as an approved care coordinator.

Chronically Ill has the meaning found for such term in the ELIGIBILITY FOR BENEFITS section of this outline and the policy.

Elimination Period means the number of calendar days shown in the policy schedule. (Refer to the LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS section of this outline for additional information.)

Family Member means your mother, father, son, daughter, brother, sister or spouse.

Home means the place where you maintain your primary independent residence. Home does not include: a Nursing Home; a hospital; an Assisted Living Facility; any other institutional setting where you are dependent on others for assistance with Activities of Daily Living; or the residence of the person providing the Home Health Care.

Home Health Care means medical and non-medical services, provided to ill, disabled or infirm persons in their Homes. Such services include, but are not limited to: (a) part-time or intermittent skilled services provided by a nurse; (b) services to support your compliance with your medication/treatment regimen; (c) home health aide services; (d) physical therapy, respiratory therapy, occupational therapy, speech therapy or audiology therapy; (e) services provided by a specialist in the field of nutrition or the administration of chemotherapy; (f) Homemaker Services; (g) Maintenance or Personal Care Services; (h) Respite Care; (i) Hospice Care.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care for compensation and employs staff who are qualified by training or experience to provide such care. The entity must: (a) be supervised by a qualified professional such as a registered nurse (RN), a licensed social worker, or a Physician; (b) keep clinical records or care plans on all patients; (c) provide ongoing supervision and training to its employees appropriate to the services to be provided; and (d) have the appropriate state licensure, accreditation or certification, where required.

Homemaker Services means those services needed to maintain an adequate Home environment such as: laundry services; routine food shopping and errands; meal preparation and cleanup; and domestic or cleaning services.

Hospice Care means palliative care to alleviate the physical, emotional and social discomfort of individuals who are terminally ill.

Hospice Care Facility means a facility which provides Hospice Care under the direction of a Physician on an inpatient basis. A Hospice Care Facility must be licensed or certified by the state in which it is located, if such license is required.

Licensed Health Care Practitioner means any of the following who is not a Family Member: a Physician; a registered nurse (RN); a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with helping you conduct Activities of Daily Living while you are Chronically Ill. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Nursing Home means a facility or distinctly separate part of a facility that is engaged primarily in providing nursing care. If required by the state in which it is located, a Nursing Home must have the appropriate state licensure, certification or registration to operate as a Nursing Home.

If the state in which it is located does not require a Nursing Home to be licensed, certified or registered, the facility must meet the following requirements:

(a) provides twenty-four (24) hour-a-day nursing care under the supervision of a licensed practical nurse (LPN), registered nurse (RN) or a Physician;
(b) maintains a daily medical record of each inpatient; and
(c) provides nursing care at skilled, intermediate, or custodial levels.

An Alzheimer's Facility or a Hospice Care Facility may be a Nursing Home if such facility meets the requirements contained in this definition for a Nursing Home located in a state which does not require licensure, certification or registration.

Nursing Home does not include a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or mental or nervous disorders; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or your primary place of residence in an area used principally for independent residential living; or a similar establishment.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action (as defined in Section 1861 (r) (1) of the Social Security Act) other than you or a Family Member. He or she must be providing services within the scope of his or her license.

Plan of Care means a written plan of services prescribed for you by a Licensed Health Care Practitioner. We reserve the right to discuss the Plan of Care with the Licensed Health Care Practitioner. We have the right to verify that your Plan of Care is appropriate and consistent with generally accepted standards for care of the Chronically Ill. The Plan of Care must specify the type, cost, frequency and providers of the services you require. The Plan of Care will be modified as required to reflect changes in your functional or cognitive abilities, social situation, and care service needs.

Policy Class means persons who are insured by us under this policy form with the same issue age, rate classification and benefits similar to the benefits under the policy. Such persons live in the same geographic area of the state as you did on the policy effective date.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill person.

Respite Care means the supervision and care of you while the Family Members or other individuals who normally provide substantial amounts of unpaid care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in your: (a) short-term or long-term memory; (b) orientation as to people, places or time; (c) deductive or abstract reasoning; and (d) judgment as it relates to safety awareness.

Substantial Assistance means either Hands-on Assistance or Standby Assistance.

(a) **Hands-on Assistance** means the physical assistance of another person without which you would be unable to perform the Activities of Daily Living.
(b) **Standby Assistance** means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, injury while you are performing the Activities of Daily Living.

Substantial Supervision means supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

10. LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

(a) services provided from a Family Member;
(b) services for which no charge would be made in the absence of insurance;
(c) for services provided outside of the United States, its possessions or territories, Canada or the United Kingdom (except as provided in the INTERNATIONAL BENEFIT section of this policy);
(d) services provided due to suicide (while sane or insane), attempted suicide or an intentionally self-inflicted injury;
(e) for treatment of alcoholism or drug addiction (except for an addiction to a prescription medication when administered in accordance with the advice of your Physician);
(f) for treatment provided in a government facility unless we are required by law to cover the charges;
(g) for treatment of an injury or sickness which would entitle you to benefits under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;
(h) for services received while this policy is not in force (except as provided in the **Extension of Benefits** section);
(i) services provided due to an act of declared or undeclared war.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY OF BENEFITS

Conditions

Except as otherwise provided in the policy, you must incur eligible expenses for Qualified Long-Term Care Services in order to receive benefits under the policy. Such Qualified Long-Term Care Services must be specified in a Plan of Care prepared for you by a Licensed Health Care Practitioner. Except for Stay-at-Home Benefits, if you are eligible for more than one type of benefit under the policy on a single day, we will pay the benefit which pays the greater amount.

Satisfying the Elimination Period

Except as otherwise provided in the policy, we will not pay benefits for eligible expenses incurred during the Elimination Period. The Elimination Period commences on the first day you are eligible for benefits under the policy and on which you: (a) are confined to a Nursing Home or an Assisted Living Facility; (b) receive Home Health Care or Adult Day Care; or (c) receive long-term care services covered under the policy that are Medicare eligible (for which benefits are not payable under the policy). The Elimination Period must be satisfied only once during the term of the policy.

Maximum Lifetime Benefit

Except as otherwise provided in the policy, any benefits paid under the policy will reduce the amount of your maximum lifetime benefit. No additional benefits are payable under the policy once the maximum lifetime benefit has been reduced to zero.

Non-Duplication of Benefits

We will not pay benefits under the policy to the extent that eligible expenses are reimbursable under Medicare or other government program (except Medicaid) or would be so reimbursable except for the application of a deductible or coinsurance amount.

Coordination of Benefits
Benefits under the policy may be reduced if benefits for eligible expenses are paid by us or one of our affiliates under another individual long-term care insurance policy. Benefits will be reduced under the policy only when payment under the policy and such other long-term care insurance policy(ies) combined would exceed the actual amount you incur for eligible expenses. In no event will we pay more under this policy than the difference between your actual eligible expenses and the amount payable by such other long-term care insurance policy(ies).

If you are insured under one or more policies without a similar Coordination of Benefits provision, such policy(ies) will be deemed primary and pay benefits first. Then, payment will be made under any policy without a similar Coordination of Benefits provision in order of effective date, from the earliest to the latest.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. You may elect one of the inflation protection options to increase your coverage. Only increases taken in accordance with one of the inflation protection options do not require proof of insurability.

5% Compound Inflation Protection (Lifetime)
If you elect the optional 5% Compound Inflation Protection Benefit, on each policy anniversary date from and after the compound inflation protection starting date, we will automatically increase the maximum monthly benefit then in effect under the policy by 5%. In addition, on each policy anniversary date from and after the compound inflation protection starting date, we will automatically increase the maximum lifetime benefit remaining at the end of the prior policy year by 5%. The increase in the maximum monthly benefit and the maximum lifetime benefit will be rounded to the nearest whole dollar.

In addition to 5% Compound Inflation Protection (Lifetime) Benefit, as described above, you may select other percentages such as: 3% 4%

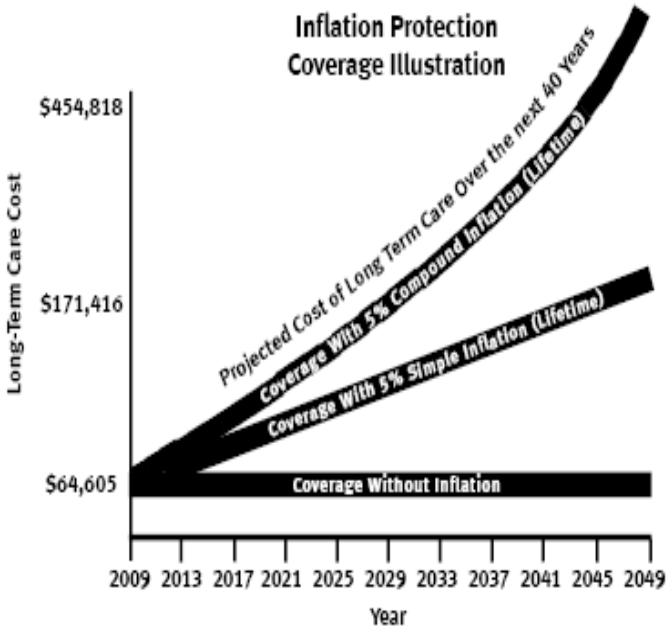
5% Compound Inflation Protection – 20 Year
If you elect the optional 5% Compound Inflation Protection -20 Year Benefit, on each policy anniversary date up to and including the 20th policy anniversary date, we will automatically increase each maximum monthly benefit then in effect under the policy by 5%. On each policy anniversary date up to and including the 20th policy anniversary date, we will automatically increase the maximum lifetime benefit remaining at the end of the prior policy year by 5%. The increase in the maximum monthly benefit and the maximum lifetime benefit will be rounded to the nearest whole dollar.

5% Simple Inflation Protection
If you elect the optional 5% Simple Inflation Protection Benefit, on each policy anniversary date, we will automatically increase the maximum monthly benefit then in effect under the policy by an amount equal to the maximum monthly benefit in effect on the policy effective date multiplied by 5%. In addition, on each policy anniversary date, we will automatically increase the maximum lifetime benefit remaining at the end of the prior policy year by an amount equal to the lesser of: (a) the maximum lifetime benefit in effect on the policy effective date multiplied by 5%; or (b) the maximum lifetime benefit remaining at the end of the prior policy year multiplied by 5%. The increase in the maximum monthly benefit and the maximum lifetime benefit will be rounded to the nearest whole dollar.

Future Purchase Option
If you elect this benefit, you may, upon written request to us, purchase the Compound Inflation Protection – Lifetime Benefit rider for the policy, on or before the fifth policy anniversary date. You will be eligible to purchase the Compound Inflation Protection – Lifetime Benefit rider if, at the time of purchase: (a) we are not waiving premium under any provision of the policy; and (b) you are not Chronically Ill and have not for the immediate two-year period received benefits under the policy.
Purchase of Compound Inflation Protection The Compound Inflation Protection – Lifetime Benefit rider will be effective on the policy anniversary date coinciding with or next following the date of your request. You may purchase the Compound Inflation Protection Lifetime Benefit only once while the policy is in force.

Your Premium Will Increase We will increase the premium for the policy if you purchase the Compound Inflation Protection – Lifetime Benefit rider. Premium will increase by an amount determined by us at the time of your purchase. We will increase the premium for the policy on the effective date of your purchase. However, any increase in benefits will NOT occur until the policy anniversary date following the effective date of your purchase.

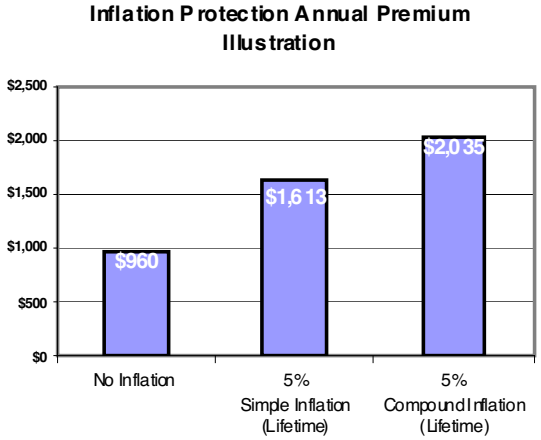
Inflation Protection – Graphic Comparisons



The chart to the left compares and contrasts the anticipated cost for one year of institutional care of a 40-year period with the maximum lifetime benefit for three types of coverage: one with 5% Compound Inflation Protection (Lifetime); one with 5% Simple Inflation (Lifetime); and one with no inflation protection at all. The chart assumes the insured starts with $64,605.

The chart to the right compares the annual premium paid by a 63-year old person for a policy with 5% Compound Inflation Protection; 5% Simple Inflation Protection; and no inflation protection, assuming the following coverage features:

- a 3-year benefit at $3000/month ($3000 times 36 months = $108,000 MLB);
- $3000/month Nursing Home MMB;
- $3000/month Assisted Living Facility MMB;
- $3000/month Home Health Care MMB; and
- an Elimination Period of 90 days.



12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application for coverage under the policy is approved, the policy provides coverage for treatment of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

13. PREMIUM

Refer to the table below to find the annual premium.

PREMIUM	
Premium Payment Mode (Adjustment Factor)	Limited Pay - Complete below.
❑ Annual (1.0)	❑ Semi-Annual (.51)
❑ Quarterly (.26)	❑ Monthly Electronic Funds Transfer (.09)
Basic Policy Coverage Premium:	$
Nonforfeiture Benefit – Shortened Benefit Period:	$
5% Compound Inflation Protection:	$
3% Compound Inflation Protection:	$
4% Compound Inflation Protection:	$
Future Purchase Option:	$
5% Compound Inflation Protection – 20 Year:	$
5% Simple Inflation Protection:	$
Full Return of Premium at Death Benefit:	$
Return of Premium at Death Less Claims Benefit:	$
Return of Premium at Death (Less Claims Paid) if Death occurs before Age 65 Benefit:	
Additional Benefit for Injury:	$
Cash Benefit:	$
Additional Rate Guarantee Period:	$
Spouse Security Benefit – 60%:	$
Spouse Shared Care Benefit:	$
Spouse Waiver of Premium Benefit:	$
Spouse Survivorship Benefit:	$
Limited Pay - 10 Year Pay Option:	$
Limited Pay - 20 Year Pay Option:	$
Limited Pay - To Age 65 Pay Option:	$
Single Premium Payment Option:	$
Waiver of Elimination Period for Home Health Care Benefit:	$
Restoration of Benefits:	$
Total Annual Premium:	$
Modal Premium:	$
(Annual X Mode Factor)	

14. ADDITIONAL FEATURES

Underwriting

Medical underwriting is required. We will underwrite your application by reviewing one or more of the following: the information submitted on your application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Extension of Benefits

If your policy lapses for nonpayment of premium while you are continuously confined in a Nursing Home or Assisted Living Care Facility, benefits will be continued under the policy.

Protection Against Unintentional Lapse

You have the right, at the time of application, to designate at least one person who is to receive notice of lapse or termination for nonpayment of premiums in addition to yourself. You may change this designation at any time. To do so, you must notify us in writing. We will remind you in writing every two years of this opportunity.

If the policy lapses due to nonpayment of premiums because you were Chronically Ill, you may request, within five months of the date of lapse that we reinstate this policy without requiring an application. You must undergo an assessment by a Licensed Health Care Practitioner and obtain a certification that you became Chronically Ill on or before the expiration of the grace period. Upon payment of all past due premiums, the policy will be reinstated as of the lapse date.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY.

LONG-TERM CARE INSURANCE

Preparing for the Personal Health Interview

WHAT IS THE PERSONAL HEALTH INTERVIEW?

Completing a personal health interview is your next step in applying for a long-term care insurance policy. The interview – typically conducted by a registered nurse – is used to assess your eligibility for long-term care insurance.

HOW IS THE INTERVIEW CONDUCTED?

Your insurance agent will set up the interview for you at your convenience.

- If you are age 71 or younger, the interview will be conducted over the telephone and will take approximately 30 to 45 minutes to complete
- If you are age 72 or older, the interview will be conducted in person and will take approximately one hour

WHAT QUESTIONS WILL I BE ASKED?

You will be asked a series of questions about your current health, the medications you take and your daily activities. Questions also will be asked to evaluate your memory and mental ability. The questions are not difficult, and will include things like:

- The name of your primary care physician and any specialists you see
- The names of the medications you take
- Your future plans for surgery, medical testing or medical consultation
- Your living arrangements and social activities
- Your use of medical devices, such as a wheelchair

WHY IS THE INTERVIEW SO IMPORTANT?

The information you provide will be used to determine if you are eligible for a long-term care insurance policy. For that reason, it's important to give the interviewer your full attention and answer all questions completely and accurately.

- Turn off the television or radio
- Move to a quiet spot where you will not be distracted
- Make sure you can hear the interviewer clearly
- Answer all questions to the best of your ability
- If a distraction should occur while the interview is being conducted, please let the nurse know and ask to reschedule the interview for a better time

YOUR INFORMATION IS STRICTLY CONFIDENTIAL

We protect your privacy by safeguarding the information you provide. Mutual of Omaha Insurance Company will use the contents of your personal health interview solely during the application process for long-term care insurance and will not release the information without your written authorization.

Use this form to prepare for the personal health interview

Take a few minutes now to collect the following information so you'll be prepared for your personal health interview.

Primary Care Physician

Name: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

Date/Reason Last Seen: _____

Specialist

Name: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

Date/Reason Last Seen: _____

Current Medications (prescription and over-the-counter)

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Frequency: _____ Frequency: _____

Your Personal Health Interview Reference Number

You will be provided a reference number when you complete your personal health interview.
Record that number here: _____