MUTUAL of OMAHA INSURANCE COMPANY
UNITED of OMAHA LIFE INSURANCE COMPANY

VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFITS SUMMARY

Mutual of Omaha

For Employees of Indian River County on 24 Pay Cycles

ELIGIBILITY – CLASS 01: ALL ELIGIBLE EMPLOYEES ELECTING THE 90 DAY ELIMINATION PERIOD OPTION	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 30 hours per week to be eligible for coverage.
Coverage Payment	You pay 100% of the premium for this coverage through easy payroll deduction.
Evidence of Insurability	If you are currently enrolled in the long-term disability plan or are a new hire, evidence of insurability is not required. If you are a current employee and have previously declined and wish to elect coverage now, you must complete evidence of insurability.
BENEFITS	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 90 days after the onset of your disabling injury or illness.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount, less other income sources.
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Monthly Benefit	$5,000 maximum / $50 minimum
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are: ▪ Prevented from performing at least one of the material duties of your regular occupation during the first 2 years of disability and after 2 years are unable to perform all of the material duties of any gainful occupation; and ▪ During the first 2 years of disability are unable to generate current earnings which exceed 99% of your monthly earnings from your regular occupation, and after 2 years are unable to generate current earnings which exceed 85% of your monthly earnings from any gainful occupation. You can be totally or partially disabled during the elimination period.
Definition of Monthly Earnings	Monthly earnings is the average gross monthly income you receive from your employer for the year immediately prior to the onset of disability, which is used to determine your benefit in the event of a claim. Earnings may include commissions, bonuses, overtime, shift differential pay or other extra compensation.
FEATURES	
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Survivor Benefit	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
Waiver of Premium	The premium for your long-term disability coverage is waived while you are receiving benefits.
Alcohol & Drug Abuse	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
Mental Disorders	For disabilities related to mental disorders, benefits are available for up to 24 months.
Specific Conditions	For disabilities related to specific conditions, benefits are available for up to 24 months.
Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	
EXCLUSIONS	
Pre-existing Conditions Exclusion	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
Other Exclusions	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.

Voluntary Long-Term Disability (LTD) Benefit Calculation

Using the example as a guide, complete the Benefit Calculation Worksheet to determine your monthly LTD benefit.

Benefit Calculation Example	
This example is for an employee earning $36,000 a year.	
A. Enter your annual salary*	$36,000.00
B. Divide "A" by 12	$3,000.00
C. Multiply "B" times the Monthly Benefit percentage - 60%	$1,800.00
D. Enter the Maximum Monthly Benefit	$ 5,000.00
E. Enter the lesser of "C" or "D"; This is your benefit amount	$1,800.00

Benefit Calculation Worksheet	
A. Enter annual salary*	
B. Divide "A" by 12	
C. Multiply "B" times your Monthly Benefit percentage – 60	
D. Enter the Maximum Monthly Benefit	$5,000
E. Enter the lesser of "C" or "D"; This is your Benefit Amount	

* If you are uncertain what your current annual salary is, Please consult your employer.

To enroll for long-term disability coverage: 1) Enter the amount from line "E" in your Benefit Calculation Worksheet into the Voluntary Long-Term Disability Benefit Amount section on your enrollment form.

Voluntary Long-Term Disability (LTD) Premium Calculation - 24 Pay Cycles

Use the rates in the Age/Rate Table to calculate your premium in the worksheet below, using the example as a guide

Age/Rate Table	
Age	Rate (% of payroll)
0-19	.105%
20-24	.105%
25-29	.105%
30-34	.185%
35-39	.228%
40-44	.332%
45-49	.514%
50-54	.754%
55-59	.910%
60-64	.949%
65-69	.949%
70+	.949%

Premium Calculation Example	
This example is for a 42-year-old employee, earning $36,000 a year.	
A. Enter your annual salary*	$36,000.00
B. Enter the rate for your age (from the Age/Rate Table)	.332%
C. Divide "B" by 100	$0.00332
D. Multiply "A" times "C"	$119.52
E. Enter the annual pay cycle	24
F. Divide "D" by "E", This is your premium cost per paycheck)	$4.98

Premium Calculation Worksheet	
A. Enter your annual salary*	
B. Enter the rate for your age (from the Age/Rate Table)	
C. Divide "B" by 100	
D. Multiply "A" times "C"	
E. Enter the annual pay cycle	24
F. Divide "D" by "E", This is your premium cost per paycheck)	

*If you are uncertain what your current annual salary is, Please consult your employer.

To enroll for long-term disability coverage: 2) Enter the amount from line "F" in your Premium Calculation Worksheet into the Voluntary Long-Term Disability Premium Amount section on your enrollment form.

MUTUAL *of* OMAHA INSURANCE COMPANY
UNITED *of* OMAHA LIFE INSURANCE COMPANY

VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFITS SUMMARY

For Employees of Indian River County on 24 Pay Cycles

ELIGIBILITY – CLASS 01: ALL ELIGIBLE EMPLOYEES ELECTING THE 180 DAY ELIMINATION PERIOD OPTION	
Eligibility Requirement	You must be actively at work (able to perform all normal duties of your job) to be eligible for coverage.
Minimum Work Hours	You must be working a minimum of 30 hours per week to be eligible for coverage.
Coverage Payment	You pay 100% of the premium for this coverage through easy payroll deduction.
Evidence of Insurability	If you are currently enrolled in the long-term disability plan or are a new hire, evidence of insurability is not required. If you are a current employee and have previously declined and wish to elect coverage now, you must complete evidence of insurability.
BENEFITS	
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 180 days after the onset of your disabling injury or illness.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount, less other income sources.
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65 or your Social Security Normal Retirement Age. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Monthly Benefit	$5,000 maximum/ $50 minimum
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are: ▪ Prevented from performing at least one of the material duties of your regular occupation during the first 2 years of disability and after 2 years are unable to perform all of the material duties of any gainful occupation; and ▪ During the first 2 years of disability are unable to generate current earnings which exceed 99% of your monthly earnings from your regular occupation, and after 2 years are unable to generate current earnings which exceed 85% of your monthly earnings from any gainful occupation. You can be totally or partially disabled during the elimination period.
Definition of Monthly Earnings	Monthly earnings is the average gross monthly income you receive from your employer for the year immediately prior to the onset of disability, which is used to determine your benefit in the event of a claim. Earnings may include commissions, bonuses, overtime, shift differential pay or other extra compensation.
FEATURES	
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Survivor Benefit	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
Waiver of Premium	The premium for your long-term disability coverage is waived while you are receiving benefits.
Alcohol & Drug Abuse	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
Mental Disorders	For disabilities related to mental disorders, benefits are available for up to 24 months.
Specific Conditions	For disabilities related to specific conditions, benefits are available for up to 24 months.
Note: Additional information about the benefits and features of this plan will be included in the summary of coverage, which you will receive after enrolling, and in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.	
EXCLUSIONS	
Pre-existing Conditions Exclusion	Disabilities that occur during the first 12 months of coverage due to a pre-existing condition during the 3 months prior to coverage are excluded.
Other Exclusions	Information about other exclusions for this plan will be included in the certificate booklet, available from your employer. Please contact your employer if you have questions prior to enrolling.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by Mutual of Omaha. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states. United of Omaha Life Insurance Company is licensed in all states but New York. In New York, Mutual of Omaha Insurance Company underwrites the plan. Policy Form Number 7000GM-MU-EZ 2001.

VOLUNTARY LONG-TERM DISABILITY (LTD) BENEFIT CALCULATION

Using the example as a guide, complete the Benefit Calculation Worksheet to determine your monthly LTD benefit.

Benefit Calculation Example	
This example is for an employee earning $36,000 a year.	
A. Enter your annual salary*	$36,000.00
B. Divide "A" by 12	$3,000.00
C. Multiply "B" times the Monthly Benefit percentage - 60%	$1,800.00
D. Enter the Maximum Monthly Benefit	$ 5,000.00
E. Enter the lesser of "C" or "D"; This is your benefit amount	$1,800.00

Benefit Calculation Worksheet	
A. Enter annual salary*	
B. Divide "A" by 12	
C. Multiply "B" times your Monthly Benefit percentage – 60	
D. Enter the Maximum Monthly Benefit	$5,000
E. Enter the lesser of "C" or "D"; This is your Benefit Amount	

* If you are uncertain what your current annual salary is, Please consult your employer.

To enroll for long-term disability coverage: 1) Enter the amount from line "E" in your Benefit Calculation Worksheet into the Voluntary Long-Term Disability Benefit Amount section on your enrollment form.

VOLUNTARY LONG-TERM DISABILITY (LTD) PREMIUM CALCULATION - 24 PAY CYCLES

Use the rates in the Age/Rate Table to calculate your premium in the worksheet below, using the example as a guide

Age/Rate Table	
Age	**Rate (% of payroll)**
0-19	.085%
20-24	.085%
25-29	.085%
30-34	.150%
35-39	.190%
40-44	.277%
45-49	.428%
50-54	.629%
55-59	.759%
60-64	.791%
65-69	.791%
70+	.791%

Premium Calculation Example	
This example is for a 42-year-old employee, earning $36,000 a year.	
A. Enter your annual salary*	$36,000.00
B. Enter the rate for your age (from the Age/Rate Table)	.227%
C. Divide "B" by 100	$0.00227
D. Multiply "A" times "C"	$119.52
E. Enter the annual pay cycle	24
F. Divide "D" by "E", This is your premium cost per paycheck)	$3.41

Premium Calculation Worksheet	
A. Enter your annual salary*	
B. Enter the rate for your age (from the Age/Rate Table)	
C. Divide "B" by 100	
D. Multiply "A" times "C"	
E. Enter the annual pay cycle	24
F. Divide "D" by "E", This is your premium cost per paycheck)	

*If you are uncertain what your current annual salary is, Please consult your employer.

To enroll for long-term disability coverage: 2) Enter the amount from line "F" in your Premium Calculation Worksheet into the Voluntary Long-Term Disability Premium Amount section on your enrollment form.

Enrollment Form

Underwritten by: United of Omaha Life Insurance Company

Employer Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

*Employer's Name: **Indian River County**			Effective Date:	Group ID: **G000AJFS**
Sub Group ID:	Location Code:	Class:	Occupation:	
*Salary:	*Date of Hire:	Hours Worked Per Week:		

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:	
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	**Benefit Amount**	**Premium Amount**	☐ **Semi-Monthly** (24/year) ☐ **Bi-Weekly** (26/Year)
Voluntary Long-Term Disability	$ per Month		

Select One Plan Option

☐ Option 1 - Benefits begin on day 91 of your disabling injury or illness $
☐ Option 2 - Benefits begin on day 181 of your disabling injury or illness $
☐ Decline

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE **DATE**

Additional Information

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.

Group Disability Insurance
Evidence of Insurability Form

Underwritten by: Mutual of Omaha Insurance Company   Home Office: Omaha, Nebraska

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

Employer's Name*		Group ID Number*
		G000 ____
Street Address		**Telephone**
		(___) ___ - ____
City*	**State***	**Zip Code**
	__	_____ - ____

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

Last Name*	First Name*	Middle Name

Street Address*	E-mail Address

City*	State*	Zip Code*	Telephone*
	__	_____ - ____	(___) ___ - ____

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

Consent to E-mail Correspondence

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

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

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

Section 4: Requested Coverage

Indicate the type of coverage you are applying for:

☐ **Short-Term Disability (STD)**   ☐ **Long-Term Disability (LTD)**   ☐ **Both STD and LTD**

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

Part A – Health Questions

Health Question 1

During the past seven years, have you ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following*: (Check all that apply.)

☐ Urinary tract or kidney?
☐ Liver or hepatitis?
☐ Anemia or blood?
☐ Skin or connective tissue?
☐ Chronic Epstein-Barr?
☐ Cancer or tumor?
☐ Alcohol or drug abuse?
☐ Spine, neck or back?
☐ Fibromyalgia or myalgia?
☐ High blood pressure, arteries or veins?
☐ Stroke or cerebral vascular condition?
☐ Diabetes or glandular condition?
☐ Stomach, upper or lower digestive tract?
☐ Coronary arteries of the heart?
☐ Lung or respiratory disorder?
☐ Chronic fatigue syndrome?
☐ Arthritis or joints (including replacements?)
☐ Breasts or reproductive organs (including implants, infertility, irregular menstruation, complications from pregnancy)?
☐ Epilepsy or any nervous, mental or emotional disorder?
☐ Neurological condition (including Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)?
☐ Any disease of the immune system (except HIV)?

☐ **None of the Above**

Health Question 2	Response*
During the past seven years, have you been diagnosed or treated by a member of the medical profession for having: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?	☐ YES ☐ NO

Health Question 3	Response*
During the past seven years, other than questions 1 and 2 above, have you: ▪ Been diagnosed or treated by a medical professional? ▪ Had surgery or been hospitalized? ▪ Had a medical or diagnostic examination or evaluation? ▪ Had or been advised to seek treatment for any illness, injury or disorder? ▪ Received medical care?	☐ YES ☐ NO

 FORM CONTINUES ON PAGE 2

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

- **Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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

Part A – Definitions of Terms Used in Section 7

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

Personal Information means information about me, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

Part B – Authorization to Receive and Disclose Personal Information

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

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

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

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

____

Part C – Application for Insurance

I apply for disability insurance for me. I understand that any insurance in excess of the guaranteed issue amount will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approve the amount. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until my certificate is issued or amended and the first premium paid.

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

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

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

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

SIGNATURE OF EMPLOYEE ______________________ **DATE** __/__/____

Section 8: Form Submission

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

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

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

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

Health Question 4	Response*
Have you been absent from work for more than five consecutive working days because of illness or injury during the past five years?	☐ YES ☐ NO
Health Question 5	**Response***
Within the past six months, have you been prescribed medication by a medical professional or taken any medication requiring a prescription?	☐ YES ☐ NO
Health Question 6	**Response***
During the past seven years, have you regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	☐ YES ☐ NO
Health Question 7	**Response***
If female, are you pregnant? If YES, please provide anticipated delivery date (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	☐ YES ☐ NO

Part B – If you responded YES questions 1, 2, 3 or 4 above, you must complete the following, as applicable:

Ques. #	Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam	Date of Occurrence (MM/DD/YYYY)	Duration (WEEKS, MONTHS OR YEARS)	Degree of Recovery (% OF FUNCTION)

Part C – If you responded YES to question 5 above, you must complete the following, as applicable:

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

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

- **Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **Arkansas/Kentucky/Louisiana/New Mexico/Ohio/ Tennessee:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- **District of Columbia/Pennsylvania:** 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.
- **Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.
- **Georgia/Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.
- **Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

 FORM CONTINUES ON PAGE 3

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

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

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

Submission Options

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

- Recommended – An electronic version can be completed online at *www.mutualofomaha.com/eoi* (Available 11/08)
- A "fillable" PDF version is available online at *www.mutualofomaha.com/module/gforms.phtml*. This version allows you to type information into the form (to ensure responses are fully legible), then print, sign and mail the form.

Important Tips for Paper Copy Submission

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

Guidelines for Section 1: Employer Information

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

Guidelines for Section 2: Employee Contact & Employment Information

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

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

Guidelines for Section 3: Employee Personal Information

All fields in this section are required.

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

Guidelines for Section 4: Requested Coverage

Indicate the type of insurance you are applying for, whether short-term disability, long-term disability or both.

Guidelines for Section 5: Health Information

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

Be sure to answer all questions as honestly and accurately as possible, and provide additional information where indicated.

For Degree of Recovery, indicate the percent of function you have recovered. (100% indicates full recovery. Any lesser percentage would be a judgment of partial recovery.)

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

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

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

To be complete, the form must be signed by you.

Notice of Information Practices

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

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

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

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

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

MIB Group, Inc. Pre-Notice

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

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is – Post Office Box 105; Essex Station; Boston, MA 02112.

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

Fair Credit Reporting Act Disclosure Statement

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

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

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

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

Investigative Consumer Reports Notice

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

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

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