

SERFF Tracking Number: MUTM-125639756 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 39056
Company Tracking Number: ROBYN GONZALES
TOI: MS051 Individual Medicare Supplement - Sub-TOI: MS051.001 Plan A
Standard Plans
Product Name: Individual Medicare Supplement Insurance - UA5916-03
Project Name/Number: United Medicare Supplement - Whole Life Combo App /UA5916-03

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Individual Medicare Supplement SERFF Tr Num: MUTM-125639756 State: ArkansasLH
Insurance - UA5916-03

TOI: MS051 Individual Medicare Supplement - SERFF Status: Closed State Tr Num: 39056
Standard Plans

Sub-TOI: MS051.001 Plan A

Co Tr Num: ROBYN GONZALES State Status: Under Review

Filing Type: Form

Co Status: Reviewer(s): Stephanie Fowler

Authors: Stacey Payton, Jan Disposition Date: 06/12/2008

Serafini, Kurt Vangreen, Robyn

Gonzales

Date Submitted: 05/22/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: United Medicare Supplement - Whole Life Combo App

Status of Filing in Domicile: Not Filed

Project Number: UA5916-03

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This form has not been filed in Nebraska, our state of domicile, as it will not be used in our home state.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/12/2008

State Status Changed: 06/09/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see letter attached under the supporting documentation tab.

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Company and Contact

Filing Contact Information

Jan Serafini, Policy Drafting and Regulatory Specialist
 jan.serafini@mutualofomaha.com
 Regulatory Affairs (402) 351-6913 [Phone]
 Omaha, NE 68175 (402) 351-5298[FAX]

Filing Company Information

United of Omaha Life Insurance Company CoCode: 69868 State of Domicile: Nebraska
 Mutual of Omaha Plaza Group Code: 261 Company Type: Life Insurance
 Omaha, NE 68175 Group Name: State ID Number:
 (402) 351-6420 ext. [Phone] FEIN Number: 47-0322111

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	05/22/2008	20459451

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	06/12/2008	06/12/2008

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Disposition

Disposition Date: 06/12/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Cover Letter	Approved	No
Supporting Document	Memorandum of Variability	Approved	No
Supporting Document	Fee Schedule Cert	Approved	No
Supporting Document	AR Credit Card Cert	Approved	No
Supporting Document	Read Cert	Approved	No
Form	Medicare Supplement/Whole Life Application	Approved	No

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Form Schedule

Lead Form Number: UA5916-03

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	UA5916-03	Application/ Medicare Enrollment Supplement/Whole Form	Application/ Medicare Enrollment Supplement/Whole Life Application	Initial		40	UA5916-03 (AR).pdf

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



Application For: Medicare Supplement Coverage Life Insurance

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:
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MEDICARE SUPPLEMENT PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT	APPLICANT B
Policy Form	Policy Form
Requested Effective Date	Requested Effective Date
Medicare Supplement Premium Collected \$	Medicare Supplement Premium Collected \$
2 [Initial] Mode A, S, Q, B 3[, ACH] 4[or CC]	2 [Initial] Mode A, S, Q, B 3[, ACH] 4[or CC]
Renewal \$	Renewal \$
Renewal Mode A, S, Q, B 4[or CC] (monthly not available)	Renewal Mode A, S, Q, B 4[or CC] (monthly not available)

1. IF APPLYING FOR MEDICARE SUPPLEMENT AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____) (area code)	Home Phone No (_____) (area code)
Current Age _____ Date of Birth ____/____/____ mo / day / yr	Current Age _____ Date of Birth ____/____/____ mo / day / yr
Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Social Security No.	Social Security No.
Medicare Health Insurance Card Number (if known or applicable)	Medicare Health Insurance Card Number (if known or applicable)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?	APPLICANT Yes <input type="checkbox"/> No <input type="checkbox"/>	APPLICANT B Yes <input type="checkbox"/> No <input type="checkbox"/>
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant / Applicant B		
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ / _____ Applicant / Applicant B		
3. Did you turn age 65 in the last 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last 6 months? If "YES," indicate your effective date. _____ / _____ / _____ Applicant / Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

3. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES" please attach proof of eligibility.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____ / ____ / ____	Issue Date ____ / ____ / ____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) If "YES," indicate termination date. _____ / _____ / _____ Applicant / Applicant B		
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ / _____ / _____ END _____ / _____ / _____ Applicant / Applicant B		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant / Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ / _____ Applicant / Applicant B		

4. IF APPLYING FOR MEDICARE SUPPLEMENT:

- During Open Enrollment or a Guaranteed Issue period, **SKIP SECTION 4 and GO TO SECTION 5.**
- NOT during Open Enrollment or a Guaranteed Issue period, **PLEASE ANSWER ALL QUESTIONS.**

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS.

If either you or Applicant B answer “YES” to any of the following questions 1-14, that person is not eligible for Medicare Supplement or Life Insurance coverage.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed with Parkinson’s Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered “NO”.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If “YES,” please list the drug and the condition in the following table.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____
_____	Medication Name (copy off pharmacy label)	_____
_____	Date Originally Prescribed	_____
_____	Frequency and Dosage	_____
_____	Diagnosis/Condition	_____

5. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE COMPLETE HOUSEHOLD DISCOUNT INFORMATION

You may be eligible for a policy with a lower rate based on your answers to the statements in this section. a. I have continuously resided with another person for the last 12 months or are married and they are also applying for this coverage. If "YES," please provide the following information. If you and Applicant B are applying for coverage on this application, do not fill out the following information.	Applicant	Applicant B
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Relationship to Applicant:

First Name _____

Last Name _____

Street Address _____

City _____ State _____ ZIP _____

b. I have continuously resided with another person for the last 12 months or are married and they have an existing Medicare supplement policy or certificate with Mutual of Omaha Insurance Company or United World Life Insurance Company or United of Omaha Life Insurance Company. If "YES," please provide the following information.	Applicant	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Relationship to Applicant:

First Name _____

Last Name _____

Street Address _____

City _____ State _____ ZIP _____

Policy/Certificate Number _____

6. IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Life Insurance, you must answer all the questions in Section 4 of the application.

APPLICANT	APPLICANT B (if applying for coverage)
Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)	Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)
Relationship to Applicant	Relationship to Applicant B
5 Face Amount: [<input type="checkbox"/> \$5,000] [<input type="checkbox"/> \$10,000] [<input type="checkbox"/> Other _____]	5 Face Amount: [<input type="checkbox"/> \$5,000] [<input type="checkbox"/> \$10,000] [<input type="checkbox"/> Other _____]
Life Insurance Premium Collected: \$	Life Insurance Premium Collected: \$
6 [Initial] Mode: A, S, Q, B 7[, ACH] or 8[CC]	6 [Initial] Mode: A, S, Q, B 7[, ACH] or 8[CC]
Renewal: \$	Renewal: \$
Renewal Mode: A, S, Q, B 8[or CC] (monthly not available)	Renewal Mode: A, S, Q, B 8[or CC] (monthly not available)

- | | | |
|---|--|--|
| 1. Are you a citizen of the United States?
If "No," complete Foreign National and Foreign Travel Questionnaire | Applicant
Yes <input type="checkbox"/> No <input type="checkbox"/> | Applicant B
Yes <input type="checkbox"/> No <input type="checkbox"/> |
|---|--|--|
2. List below all life insurance policies and/or annuity contracts on the Applicants that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) **If none, check the following box:** None
3. List below if you have had or intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application.
The Producer shall comply with any additional state and/or company replacement requirements.

Company	Applicant	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Any person who, with intent to defraud or knowingly that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

Dated at _____, on _____, _____
 City State Month Day Year Applicant's Signature

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

I wish to apply for a Life insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. The life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policy owner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the application, from the date the application is approved by United of Omaha's Underwriting Department to the date the policy is delivered and accepted by the policy owner.

Dated at _____, on _____, _____
 City State Month Day Year Applicant's Signature

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

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

 (Signature of Licensed Producer)

 (Signature of Licensed Producer)

 PRODUCER STAMP

 PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>
<hr/> <hr/> <hr/>	Medication Name (copy off pharmacy label) <hr/> Date Originally Prescribed <hr/> Frequency and Dosage <hr/> Diagnosis/Condition <hr/>	<hr/> <hr/> <hr/>

SECTION FOR ADDITIONAL COMMENTS

Applicant (please attach a separate sheet if needed)	Applicant B (please attach a separate sheet if needed)

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Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice **Approved** 06/12/2008
Comments:
Attachment:
 AR Certif of Compliance with Rule 19.pdf

Review Status:
Satisfied -Name: Application **Approved** 06/12/2008
Comments:
 This is an application only filing. The application is attached under Form Schedule tab.

Review Status:
Bypassed -Name: Health - Actuarial Justification 05/08/2008
Bypass Reason: N/A
Comments:

Review Status:
Bypassed -Name: Outline of Coverage 05/08/2008
Bypass Reason: N/A
Comments:

Review Status:
Satisfied -Name: Cover Letter **Approved** 06/12/2008
Comments:
Attachment:
 Med Supp Cover Letter.pdf

Review Status:
Satisfied -Name: Memorandum of Variability **Approved** 06/12/2008
Comments:
Attachment:

SERFF Tracking Number: MUTM-125639756 State: Arkansas
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Project Name/Number: United Medicare Supplement - Whole Life Combo App /UA5916-03

Satisfied -Name: Fee Schedule Cert **Review Status:** Approved 06/12/2008
Comments:
Attachment:
AR Fee Schedule Cert UA5916-03.pdf

Satisfied -Name: AR Credit Card Cert **Review Status:** Approved 06/12/2008
Comments:
Attachment:
AR Credit Card Cert.pdf

Satisfied -Name: Read Cert **Review Status:** Approved 06/12/2008
Comments:
Attachment:
AR Read Cert.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: United of Omaha Insurance Company

Form Number(s):UA5916-03

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.


Signature of Company Officer

Daniel J. Kennelly

Name

Vice President and Chief Compliance Officer

Title

May 22, 2008

Date

UNITED of OMAHA

UNITED of OMAHA LIFE INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
402 342 7600



May 22, 2008

Arkansas Department of Insurance
Attn: Compliance - Life & Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: United of Omaha Life Insurance Company
NAIC # 261-69868 FEIN 47-0322111
Individual Medicare Supplement Insurance
Medicare Supplement/Whole Life Application UA5916-03

On behalf of United of Omaha Life Insurance Company, I am submitting the above-captioned form in final printed format for your review and approval. The individual Medicare Supplement and Whole Life combination application is new and not intended to replace any previously approved forms. This form contains no unusual or controversial items according to normal company and industry standards and to the best of my knowledge complies with all of your applicable statutes.

Currently if a customer is interested in both a Medicare Supplement and a Whole Life policy, two applications must be completed. To enable a quicker and more efficient experience for our senior age clients the enclosed application is being filed. This application will only be used by our career agents and independent brokers/producers that are licensed to sell both the Medicare Supplement and Whole Life products.

We wish to use application UA5916 with our Medicare Supplement policy forms UM1-21324, UM4-21325, UM5-21326 previously approved by your department on April 25, 2008. In addition, we wish to use this application with Whole Life policy Form C501LAR08P which is being filed concurrently under separate cover with the life division of your department.

Please see attached Application Memorandum of Variability which identifies the sections of the application that are variable and explains the reason for the variability.

This form has not been filed in Nebraska, our state of domicile, as it will not be used in our home state.

The Flesch score of this form meets or exceeds your state's Flesch readability requirements when scored with the base policy.

Arkansas Department of Insurance
May 22, 2008
Page 2

Your review and approval of this submission will be most appreciated. If I may be of additional assistance to you, please feel free to call me collect.

Sincerely,

A handwritten signature in cursive script that reads "Robyn Gonzales". The letters are fluid and connected, with a prominent loop on the 'y' and a long tail on the 's'.

Robyn Gonzales
Product and Advertising Compliance Analyst
Regulatory Affairs

Phone: 402-351-6748

Fax: 402-351-5298

E-mail: Robyn.Gonzales@mutualofomaha.com

**Memorandum of Variability
Explanation of Variable Statements and Fields
For United of Omaha Life Insurance Company
Application Form UA5916-03**

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

Reference to Independent Distribution Network (IDN) is our Brokerage distribution channel.

Reference to Automated Clearing House (ACH) is a nationwide batch oriented electronic funds transfer system which provides for inter-bank clearing of electronic payments for participating depository financial institutions.

<i>Variable Statements/Fields</i>	<i>How or When Used</i>
PAGE 1	
1. [For United of Omaha Career Brokers Only: ... etc]	May or may not print depending on administrative use.
For <u>APPLICANT</u> and <u>APPLICANT B</u> 2. [Initial] Mode A, S, Q, B 2. [Renewal \$_____] [Renewal Mode A, S, Q, B]	Either both of these variables will print or both will not, depending on whether we will offer different initial and renewal premium payment modes at application. May or may not print depending on distribution or marketing criteria.
3. [, ACH]	May or may not print as payment option for IDN distribution only.
4. [or CC]	May or may not print as Credit Card payment option for future use depending on marketing criteria.
PAGE 5	
For <u>APPLICANT</u> and <u>APPLICANT B</u> 5. Face Amount [<input type="checkbox"/> [\$5,000] <input type="checkbox"/> [\$10,000] <input type="checkbox"/> Other_____]	The number of face amount options and the face amounts listed may change depending on distribution and marketing criteria.
For <u>APPLICANT</u> and <u>APPLICANT B</u> 6. [Initial] Mode A, S, Q, B 6. [Renewal \$_____] [Renewal Mode A, S, Q, B]	Either both of these variables will print or both will not, depending on whether we will offer different initial and renewal premium payment modes at application. May or may not print depending on distribution or marketing criteria.
7. [, ACH]	May or may not print as payment option for IDN distribution only.
8. [or CC]	May or may not print depending on distribution or marketing criteria.

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868

Company Contact Person & Phone: Robyn Gonzales

402-351-6748

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* _____ X \$50 = \$ _____

**Retaliatory \$ _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ X \$50 = _____

**Retaliatory \$ _____

Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* 1 X \$20 = \$20.00

**Retaliatory \$ _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ X \$25 = \$ _____

**Retaliatory \$ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority

* _____ X \$400 = _____

Filing to amend Certificate of Authority.

*** _____ X \$100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**

Arkansas Insurance Department

Mike Huckabee
Governor



Julie Benafield Bowman
Commissioner

Please read and acknowledge your understanding and assurance of complying with the following requirements:

1. If a sponsor or endorser is involved such as a bank, school, retail store, etc., it must be ascertained whether that sponsor is to receive any form of compensation for the use of the card. If so, this must be disclosed to the insured. If there is compensation, the sponsor would need to be licensed to sell insurance.
2. The company must certify that failure to pay the credit card bill will not affect the premium payment.
3. If the credit card company does not pay the premium for any reason, the insurance company must notify the insured of this and allow a thirty day Grace Period for the insured to pay the premium.



SIGNATURE

May 22, 2008

DATE

United of Omaha Life Insurance Company

COMPANY

CC-1

CERTIFICATION

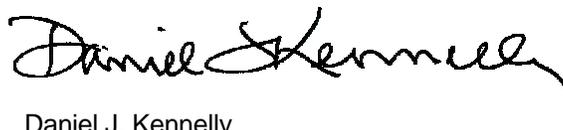
This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
UA5916-03	Medicare Supplement and Whole Life Application	*

* When scored with base policy, this form meets or exceeds Flesch score of 40.

United of Omaha Life Insurance Company

Date May 22, 2008



Daniel J. Kennelly
Vice President and Chief Compliance Officer