

SERFF Tracking Number: MUTM-126322971 State: Arkansas
Filing Company: Mutual of Omaha Insurance Company State Tracking Number: 43822
Company Tracking Number: JOANNE NAJDZIN
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Accident Medical Expense and Worker's Comp Riders - OML1M
Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OML1M

Filing at a Glance

Company: Mutual of Omaha Insurance Company

Product Name: Accident Medical Expense and SERFF Tr Num: MUTM-126322971 State: Arkansas

Worker's Comp Riders - OML1M

TOI: H111 Individual Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 43822
Closed

Sub-TOI: H111.004 Other

Co Tr Num: JOANNE NAJDZIN

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Mary Cleasby, Shelly

Disposition Date: 10/28/2009

Kaipust, Stacey Payton, Jan

Serafini, Kurt Vangreen, Mike

DiLorenzo, Mary Gregg, Krysia

Gannon, Ellen Cochran, Joanne

Najdzin, Kristin Miller

Date Submitted: 10/15/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Accident Medical Expense and Worker's Comp Riders

Status of Filing in Domicile:

Project Number: OML1M

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/28/2009

Explanation for Other Group Market Type:

State Status Changed: 10/28/2009

Deemer Date:

Created By: Shelly Kaipust

Submitted By: Shelly Kaipust

Corresponding Filing Tracking Number:

Filing Description:

October 15, 2009

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

RE: Mutual of Omaha Insurance Company
NAIC # 261-71412 FEIN # 47-0246511
Individual Sickness & Accident Insurance
Disability Income Insurance
Rider Forms OML1M, OML2M and OML3M
Application Form MA5952-03
Actuarial Memorandum and Rate Schedules

Enclosed for filing with your Department are copies of the following individual disability income insurance forms. These forms are intended as enhancements to our currently existing disability income products. The three riders listed below are new and are not intended to replace any previously approved form.

FORM # DESCRIPTION RATE SCHEDULE

OML1M Accident Medical Expense Benefits Rider OML1M AR Base Rate 08/26/2009 0001
OML2M Worker's Compensation Exclusion Amendment Rider N/A
OML3M Worker's Compensation Exclusion Amendment Rider N/A
MA5952-03 Application for Disability Income Insurance N/A

Accident Medical Expense Benefits Rider OML1M is an optional rider available for new business sales. The rider provides benefits for supplies and the services of a physician, nurse, hospital, and urgent care center received due to an injury. This rider was developed for use with the following Accident-Only Disability Income policies approved by your Department on January 10, 2007: D83-20900 and D83-20901. This rider may also be used with other appropriate forms.

Worker's Compensation Exclusion Amendment Riders OML2M and OML3M remove the worker's compensation exclusion from all in-force and new business D82 and D83 policies. The riders replace the exclusion with a more favorable limitation for the insured at no added premium cost. Rider OML2M was drafted for use with the following policies: D82-20898 and D82-20899. Rider OML3M was drafted for use with the above referenced D83 policies. We are filing two separate riders because the D83 policies contain a section titled "Exclusions," while the D82 uses the title "Exclusions and Limitations."

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TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
Product Name: Accident Medical Expense and Worker's Comp Riders - OMLIM
Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OMLIM

Application MA5952-03 is new and is being filed to replace Application MA5904, previously approved by your Department on January 10, 2007. Application MA5952-03 will be used in conjunction with the above referenced D82 and D83 policies, in addition to the D81 policies and other appropriate disability income products. Policy Forms D81-20896 and D81-20897 were approved by your Department on January 10, 2007. Solicitation of our disability income policies will be conducted by independent brokers and producers.

We would like to request an extension of use for Drug Usage Questionnaire M25816, Alcohol Use Questionnaire M25817 and Avocation Questionnaire M25818 for use with Application MA5952-03. These forms were previously approved by your department on January 10, 2007. They will be used to obtain additional details if the applicant answers "yes" to certain questions on the Application form.

In the future, we may use electronic and voice signature options with this application. Verification of the signature will be done by matching and storing the name, address, phone number, and social security number of the applicant with the applicant's electronic signature. We will retain electronic signatures indefinitely for purposes of comparison.

Please see attached Memorandum of Variability regarding all variable options for Application MA5952-03. We ask that all application information shown in brackets be filed as variable to accommodate any changes in marketing criteria and the needs of our different distribution channels.

An Actuarial Memorandum and rate schedule pages for the Accident Medical Expense Benefits Rider are also enclosed for your review, as there is a premium cost associated with the rider. There is no specific premium rate associated with the Worker's Compensation Exclusion Amendment Riders, so there is no actuarial memo enclosed for those riders.

Your review and approval of this submission will be greatly appreciated. Please feel free to contact me if you have any questions or concerns.

Sincerely,

Joanne Najdzin
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-2471
Fax: 402-351-5298
E-mail: Joanne.Najdzin@mutualofomaha.com

Company and Contact

SERFF Tracking Number: MUTM-126322971 State: Arkansas
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Filing Contact Information

Joanne Najdzin, Product & Advertising joanne.najdzin@mutualofomaha.com
 Compliance Analyst
 4 - Regulatory Affairs Division 402-351-2471 [Phone]
 Mutual of Omaha 402-351-5298 [FAX]
 Mutual of Omaha Plaza
 Omaha, NE 68175

Filing Company Information

Mutual of Omaha Insurance Company CoCode: 71412 State of Domicile: Nebraska
 Mutual of Omaha Plaza Group Code: 261 Company Type: Health Insurance
 Omaha, NE 68175 Group Name: State ID Number:
 (402) 351-6420 ext. [Phone] FEIN Number: 47-0246511

Filing Fees

Fee Required? Yes
 Fee Amount: \$130.00
 Retaliatory? No
 Fee Explanation: \$20.00 each for 4 forms = \$80.00
 \$50.00 each for 1 rate = \$50.00 for a total of \$130.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Mutual of Omaha Insurance Company	\$130.00	10/15/2009	31320058

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/28/2009	10/28/2009

SERFF Tracking Number: *MUTM-126322971* *State:* *Arkansas*
Filing Company: *Mutual of Omaha Insurance Company* *State Tracking Number:* *43822*
Company Tracking Number: *JOANNE NAJDZIN*
TOI: *H111 Individual Health - Disability Income* *Sub-TOI:* *H111.004 Other*
Product Name: *Accident Medical Expense and Worker's Comp Riders - OMLIM*
Project Name/Number: *Accident Medical Expense and Worker's Comp Riders/OMLIM*

Disposition

Disposition Date: 10/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MUTM-126322971 State: Arkansas
 Filing Company: Mutual of Omaha Insurance Company State Tracking Number: 43822
 Company Tracking Number: JOANNE NAJDZIN
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Accident Medical Expense and Worker's Comp Riders - OML1M
 Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OML1M

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Memo of Variable Material - Application	Approved-Closed	Yes
Form	Accident Medical Expense Benefits Rider	Approved-Closed	Yes
Form	Worker's Compensation Exclusion Amendment Rider	Approved-Closed	Yes
Form	Worker's Compensation Exclusion Amendment Rider	Approved-Closed	Yes
Form	Application for Disability Income Insurance	Approved-Closed	Yes
Rate	OML1M Arkansas Rates	Approved-Closed	Yes

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 Product Name: Accident Medical Expense and Worker's Comp Riders - OML1M
 Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OML1M

Form Schedule

Lead Form Number: OML1M

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/28/2009	OML1M	Policy/Contract	Accident Medical Expense Benefits Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	Accident Medical Expense Benefits Rider OML1M.pdf
Approved-Closed 10/28/2009	OML2M	Policy/Contract	Worker's Compensation Exclusion Certificate: Amendment Amendment, Insert Page, Endorsement or Rider	Initial		0.000	Worker's Comp Exclusion Amendment Rider OML2M.pdf
Approved-Closed 10/28/2009	OML3M	Policy/Contract	Worker's Compensation Exclusion Certificate: Amendment Amendment, Insert Page, Endorsement or Rider	Initial		0.000	Worker's Comp Exclusion Amendment Rider OML3M.pdf
Approved-Closed 10/28/2009	MA5952-03	Application/Form	Application for Disability Income Insurance	Initial		0.000	MA5952-03 (AR).pdf

MUTUAL OF OMAHA INSURANCE COMPANY

ACCIDENT MEDICAL EXPENSE BENEFITS RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy, this rider will control.

Rider Date (same as Policy Date if no date is shown) _____

Rider Premium (included in the policy premium if no amount is shown) \$ _____

DEFINITIONS

The definitions shown in the policy apply to this rider. In applying them, substitute "rider" for "policy." In addition, the following definitions apply to this rider.

Deductible Amount means the amount of eligible Expense shown on the policy schedule that must be satisfied by you before benefits are payable.

Expense means charges you incur:

- (a) as the result of an Injury; and
- (b) for which services and supplies are payable under the terms of this rider.

A Physician must order or prescribe the services and supplies. Expense for any service or supply will be considered incurred on the date it is received. Not included is expense in excess of the Usual and Customary Charge for any service or supply.

Hospital means any of the following places:

- (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located;
- (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility;
- (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; or
- (d) a place certified as a hospital by Medicare.

Not included is a hospital or institution or a part of a hospital or institution which is licensed or used principally:

- (a) for the care or treatment of drug addicts or alcoholics; or
- (b) as a clinic, rehabilitation facility, continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

Maximum Benefit means the maximum dollar amount we will pay under this rider for Accident Medical Expense Benefits for any one Injury. All benefits payable under this rider apply to the maximum benefit. The maximum benefit is shown on the policy schedule.

Urgent Care Center means a free-standing medical facility that is not part of a Hospital, where patients are treated on a walk-in basis, without an appointment, and receive immediate medical care. If required by the state in which it is located, an urgent care center must have the appropriate state licensure, certification, or registration to operate as an urgent care center.

Usual and Customary Charge means the lesser of:

- (a) the fees identified by us as the usual fees charged by health care providers for similar services or supplies provided to persons with comparable medical conditions or impairments in the same geographical area. When there is, in our determination, insufficient data available for a particular service or supply, we will expand the geographical area as needed. We may use a commercially available healthcare charge information database (or other database of comparable purpose) to determine the fees; or
- (b) the actual fee charged by a health care provider for a particular service or supply.

ACCIDENT MEDICAL EXPENSE BENEFITS

When you sustain an Injury, we will pay the Expense you incur in excess of the Deductible Amount, if any, for the following services and supplies:

- (a) Services of a Physician;
- (b) Services of a registered graduate nurse (RN), other than you or a member of your family;
- (c) Treatment, services and supplies provided by a Hospital; and
- (d) Treatment, services and supplies provided by an Urgent Care Center.

Only services and supplies received within 26 weeks from the date of the Injury are covered. Total benefits payable for any one Injury are limited to the Maximum Benefit. Total lifetime benefits payable under this rider are limited to ten times the Maximum Benefit.

EXCLUSIONS

The Exclusions shown in the policy apply to this rider. In applying them, substitute "rider" for "policy."

In addition, we will not pay benefits for dental care or treatment.

Furthermore, any exclusion under your policy for "loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law" is removed and replaced by the following limitation:

Worker's Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law will be reduced by 50%.

TERMINATION

This policy will terminate on the earliest of:

- (a) the date your policy terminates;
- (b) the date total lifetime benefits paid under this rider equal ten times the Maximum Benefit; or
- (c) when you reach Age 67.

Mutual of Omaha Insurance Company



Corporate Secretary

MUTUAL OF OMAHA INSURANCE COMPANY

WORKER'S COMPENSATION EXCLUSION AMENDMENT RIDER

This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy, this rider will control.

Rider Date (same as the policy date if no date is shown) _____

WORKER'S COMPENSATION EXCLUSION AMENDMENT

The EXCLUSIONS AND LIMITATIONS section of your policy is amended as follows.

Any exclusion under your policy for "loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law" is removed and replaced by the following limitation:

Worker's Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law will be reduced by 50%.

TERMINATION

This rider terminates when your policy terminates.

Mutual of Omaha Insurance Company



Corporate Secretary

MUTUAL OF OMAHA INSURANCE COMPANY

WORKER'S COMPENSATION EXCLUSION AMENDMENT RIDER

This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy, this rider will control.

Rider Date (same as the policy date if no date is shown) _____

WORKER'S COMPENSATION EXCLUSION AMENDMENT

The EXCLUSIONS section of your policy is amended as follows.

Any exclusion under your policy for "loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law" is removed and replaced by the following limitation:

Worker's Compensation Limitation

Benefits payable for loss for which benefits are provided under any state or federal worker's compensation, employer's liability, or occupational disease law will be reduced by 50%.

TERMINATION

This rider terminates when your policy terminates.

Mutual of Omaha Insurance Company

A handwritten signature in black ink that reads "Michael Huss". The signature is written in a cursive, slightly stylized font.

Corporate Secretary

Manager/Commission Code (Required Field for Brokerage)	District Sales Manager/Associate Marketer	Application Reviewed By



Application For:

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

- 1 ACCIDENT ONLY DISABILITY INSURANCE
 2 SHORT-TERM DISABILITY INSURANCE
 LONG-TERM DISABILITY INSURANCE
 BUSINESS OPERATING EXPENSE DISABILITY INSURANCE

SECTION A GENERAL INFORMATION - COMPLETE FOR ALL CASES PROPOSED INSURED INFORMATION

<p>1. Proposed Insured's Name (First, Middle, Last) _____</p> <p>2. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male</p> <p>3. Age _____ DOB ____/____/____</p> <p>4. Birth State _____</p> <p>5. Social Security Number _____ - _____ - _____</p> <p>6. Height (Ft & In) _____ Weight (Lbs) _____</p> <p>7. Home Tel. Number (_____) _____ Daytime Tel. Number (_____) _____ Best Time to Call _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.</p> <p>8. Legal Residence Address (Number, Street, City, State, Zip) _____ _____</p> <p>9. Mailing Address for Premium Notices (if different than above) _____ _____</p> <p>10. ³ [E-Mail Address (optional) _____]</p> <p>11. Citizenship Status (check one): <input type="checkbox"/> U.S. Citizen, or <input type="checkbox"/> Permanent Resident (Form I-551) Cardholder who has resided in the U.S. at least 3 consecutive years. If checked, please complete Foreign Travel Questionnaire. ⁴ <input type="checkbox"/> Other (Please explain) _____]</p>	<p>12. Employer _____ Address _____ Business Phone Number _____ Occupation _____ List exact duties _____</p> <p>13. Are you actively working at least 30 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. How long have you been employed in your current position? _____ Years _____ Months</p> <p>15. Proposed Insured's Employment Status: <input type="checkbox"/> Employee (No Ownership) <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partner in Partnership _____ % Ownership <input type="checkbox"/> Shareholder in Sub "S" Corp. _____ % Ownership <input type="checkbox"/> Owner of C - Corp. _____ % Ownership</p> <p>16. Do you have any part-time or off-season occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," list exact duties/hours per week) _____</p> <p>17. Are you a member of an approved Association Group or Franchise? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," full name of organization _____ _____ Date joined (Mo./Yr.) _____</p> <p>18. Full name of beneficiary _____ Relationship to Proposed Insured _____</p>
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OTHER COVERAGE AND REPLACEMENT INFORMATION

1. Are you covered under or eligible for: (Check all that apply)

The Federal Employee's Compensation Act (FERS or CSRS)? Yes No

The Railroad Retirement Act? Yes No

Workers Compensation? Yes No

2. Are you currently applying for, or do you have in force other disability income coverage, such as: (1) Individual Disability Income; (2) Sick Pay, Association, or Group Disability Plan; or (3) Business Expense or Buy/Sell Insurance?... Yes No

If "Yes," complete the following information:

Company or Source	Pending or Inforce (P/I)	Type (1,2,3)	Benefit Amt. or % of Income	Elim. Period	Benefit Period	% of Premium Paid by Employer	Will coverage be replaced?
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Complete only if replacing Mutual of Omaha Insurance Company in-force coverage with another Mutual of Omaha Insurance Company policy.

I am requesting termination of my Policy No. _____ on the effective date of the new policy for which I am applying. I understand that all benefits under the policy being terminated will cease on the effective date of the new policy. **NOTE:** Benefits for which you apply may not take effect whenever there is duplication of benefits which would result in excess coverage.

INCOME INFORMATION

1. Income information (Attach financial records if required. See underwriting guide for details)	Current Year	Prior Year
(a) Gross Annual Earned Income	\$ _____	\$ _____
(b) If self employed , net annual earned income from your occupation (after business expenses and before taxes).....	\$ _____	\$ _____
(c) Bonus, First Year Commissions and other incentive payments.....	\$ _____	\$ _____
(d) Other Earned Income (Part-time, off-season, etc.)	\$ _____	\$ _____
Total	\$ _____	\$ _____

2. During the last 12 months did you receive unearned income (such as dividends, interest, net rentals, pension or renewal commissions) reportable for federal tax purposes or does your tax exempt unearned income exceed \$1,500 per month? Yes No

If "Yes," monthly average over last 12 months \$ _____

SECTION B Complete only if applying for Accident Only Disability Insurance

<p>1. During the last 5 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamine and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit a Drug or Alcohol Use Questionnaire)</p> <p>2. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," submit an Avocation Questionnaire)</p>	<p>3. Other than previously answered, during the last 3 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give details below. (Attach a separate signed sheet if necessary.)</p>
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Diagnosis of injury, disability or impairment	Month and Year	Details of Treatment	Was surgery performed?	Degree of recovery	Name and address of doctor/hospital
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION C Complete only if applying for SHORT-TERM DISABILITY, [or] LONG-TERM DISABILITY or BUSINESS OPERATING EXPENSE Insurance.

1. During the last 10 years, have you received medical care for or had any disease or disorder associated with the following? Check all that apply. Provide explanation for all checked boxes in number 10.

<input type="checkbox"/> Kidney or Urinary Tract <input type="checkbox"/> Cancer or Tumor <input type="checkbox"/> Heart or Coronary Arteries <input type="checkbox"/> Liver or Hepatitis <input type="checkbox"/> Stroke or Cerebral Vascular condition <input type="checkbox"/> Diabetes or Glandular condition <input type="checkbox"/> Psychological, Emotional or Psychiatric condition <input type="checkbox"/> Upper or Lower Digestive Tract <input type="checkbox"/> Spine, Neck or Back <input type="checkbox"/> High Blood Pressure, Peripheral Vascular Disease <input type="checkbox"/> Arthritis or Joints (including replacements)	<input type="checkbox"/> Anemia or Blood <input type="checkbox"/> Lung or Breathing Problem <input type="checkbox"/> Breast or Male/Female Reproductive Organs (such as implants, infertility, irregular menstruation, complication of pregnancy) <input type="checkbox"/> Neurological condition (such as Multiple Sclerosis, Parkinson's, seizures, Alzheimer's) <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Skin or Connective Tissue <input type="checkbox"/> Fibromyalgia or Myalgia <input type="checkbox"/> None of These
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SECTION [C] Complete only if applying for SHORT-TERM DISABILITY [,] [or] LONG-TERM DISABILITY [or BUSINESS OPERATING EXPENSE Insurance. - continued]

- 2. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)? Yes No
- 3. During the last 6 months, have you (a) been prescribed medication(s), or (b) taken any medication(s) prescribed by a physician, or (c) regularly used over-the-counter medication(s)?..... Yes No
If "Yes," please list below. (Attach a separate signed sheet if necessary.)

Medication Name
Dosage/Frequency
Date
Reason
Prescribing Physician / Address
Phone Number

- 4. During the last 12 months, have you used any form of tobacco or any form of nicotine replacement therapy (such as nicotine gum, patch or spray)? Yes No
- 5. During the last 10 years, have you been treated for alcoholism or have you used unlawful drugs (such as cocaine, methamphetamines and hallucinogens) or used prescription drugs (such as sedatives, tranquilizers, or narcotics) other than as prescribed? Yes No
(If "Yes," submit a Drug or Alcohol Use Questionnaire)
- 6. During the last 3 years, have you participated in any hazardous activities more than once, such as motor sports racing, boat racing, rock or mountain climbing, sky diving, hang gliding, skin or scuba diving? Yes No
(If "Yes," submit an Avocation Questionnaire)
- 7. Have you: (a) ever been declined, postponed, limited or asked to pay an extra premium for disability benefits by any insurance company? Yes No
If "Yes," provide details/date _____

(b) ever applied for or received disability benefits of any kind?..... Yes No
If "Yes," provide details/date _____
- 8. Are you pregnant?..... Yes No
- 9. Other than previously answered, during the last 5 years have you received, or been advised by a healthcare provider (including chiropractor) to receive, diagnostic testing or treatment for any chronic medical condition, medical impairment or disability?..... Yes No

10. Complete this section to expand on questions 1 through 9 in Section C. (Attach a separate signed sheet if necessary.)

Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration of the Condition	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

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SECTION [D] Complete only if applying for BUSINESS OPERATING EXPENSE Insurance

- 1. Is your business conducted at your place of residence? Yes No
If "Yes," what percent of your duties are performed outside of your place of residence? _____ %
- 2. Date business established?..... _____ / _____ / _____
- 3. What average monthly operating expenses do you incur (or your portion if a joint tenant) for the following? (Use the average monthly operating expenses incurred for the preceding 12 months.)

Average Monthly Expenses:

No. of employees _____	Water \$ _____
Employees' salaries \$ _____	Telephone \$ _____
Interest on loans \$ _____	Postage and stationery \$ _____
Mortgage interest payments \$ _____	Equipment rental \$ _____
Insurance (casualty/liability) \$ _____	Laundry \$ _____
Property taxes (real and personal) \$ _____	Other fixed operating expenses (please itemize)
Depreciation (office equipment only) \$ _____	_____ \$ _____
Rent (including land rental) \$ _____	_____ \$ _____
Electricity \$ _____	
Heat \$ _____	Total Monthly Expenses \$ _____

SECTION E**PLAN INFORMATION****ACCIDENT ONLY DISABILITY INSURANCE**

Monthly Benefit Amount \$ _____

Elimination Period: 0 Days 7 Days 14 Days 30 Days 60 Days 90 DaysBenefit Period: 3 Months 6 Months 12 Months 24 Months**Optional Riders:** Hospital Confinement Accident Indemnity Benefits Rider \$125 \$250 \$350 \$500] Accident Medical Expense RiderMaximum Benefit: \$0,000 \$0,000 \$0,000 \$0,000]**SHORT-TERM DISABILITY INSURANCE**

Monthly Benefit Amount \$ _____

Elimination Period **[Accident/Sickness]:** 0/7 Days 7 Days 0/14 Days 14 Days
 30 Days 60 Days 90 DaysBenefit Period: 3 Months 6 Months 12 Months 24 Months**Optional Riders:** Return of Premium Benefit Rider (check one option) 50% 80%] Hospital Confinement Indemnity Benefits Rider \$125 \$250 \$350 \$500] Critical Illness Benefits Rider (check one option) \$5,000 \$10,000 \$15,000 \$25,000]**LONG-TERM DISABILITY INSURANCE**

Base Monthly Benefit Amount \$ _____ SIS Monthly Benefit Amount \$ _____

Elimination Period: 60 Days 90 Days 180 Days 365 DaysBenefit Period: 2 Years 5 Years 10 Years To Age 67**Optional Riders:** SIS (Social Insurance Supplement) Benefits RiderDo you have any dependent children age 17 or under? Yes NoAre you covered under the Social Security Act? Yes No Return of Premium Benefit Rider (check one option) 50% 80%] Hospital Confinement Indemnity Benefits Rider (check one option) \$125 \$250 \$350 \$500] Critical Illness Benefits Rider (check one option) \$5,000 \$10,000 \$15,000 \$25,000] Extended Proportionate Disability Benefits Rider Future Insurability Option (FIO) Rider Extended Own-Occ. Disability Defin. Amend. Rider Non-Cancellable Amendment Rider Cost-of-Living Adjustment (COLA) Rider**BUSINESS OPERATING EXPENSE DISABILITY INSURANCE**

Monthly Benefit Amount \$ _____

Elimination Period: 30 Days 60 Days 90 Days 180 Days 365 DaysBenefit Period: 12 Months 18 Months**Optional Riders:** Accidental Death Rider Benefit Amt. \$ _____] Accidental Death and Dismemberment Rider Benefit Amt. \$ _____]

SECTION F

PREMIUM COLLECTION

Billing Options:

13 [1.] [No Cash With App (Effective Date = Issue Date)
 BSP]

14 [2.] [Cash With App (Effective Date = Application Date)
Initial Premium Collected \$ _____ Renewal Premium \$ _____
 BSP (If BSP is selected, collect [2] months of premium.)
 Quarterly
 Semiannual
 Annual]

15 [3.] [Payroll Deduction [(only available with Accident Only plan)]
Add to Existing PRD – Group Number.....
First Deduction Date
Number of Deductions.....
Effective Date

16 [4.] [Credit Card
 By signing this application, I authorize the initial premium for this coverage to be automatically billed through my credit card account.
 VISA® Plan code MasterCard® Plan code
_____|_____|_____|_____|_____|_____|_____|_____|_____|_____| Expiration Date ____/____]

By signing this application, I authorize the initial premium for this coverage to be billed through my credit card account.
 VISA® Plan code MasterCard® Plan code
_____|_____|_____|_____|_____|_____|_____|_____|_____|_____| Expiration Date ____/____]

[Renewal Premiums:
 BSP
 Quarterly
 Semiannual
 Annual]

SECTION G

Complete only if Billing Mode is BSP

AUTHORIZATION TO WITHDRAW FUNDS BY MUTUAL OF OMAHA INSURANCE COMPANY ("MUTUAL OF OMAHA")

I authorize 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.

- 1. Specify the date the premiums will be withdrawn: 1st of the Month or 15th of the Month
- 2. Attach your check from the account from which premiums will be withdrawn or provide routing and account number.
Routing Number _____ Account Number _____

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau), insurers, employers, consumer reporting agencies and any other organization, institution, or person that has records or knowledge of me or my health 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, prescription drug records, drug or alcohol use and other information such as 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. 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 will receive a copy of this authorization and that a copy is as valid as the original.

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: medical records, an underwriting assessment, a medical examination, or other information.
3. 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, and (c) the insurance applicant is, as of the policy application date, determined to be eligible for the exact insurance 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. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issuance. If the applicant has made an advance premium payment, applicant agrees to the terms and conditions of the Conditional Receipt. Applicant agrees that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. Applicant acknowledges that if his or her application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to applicant, without interest. No insurance coverage will be in effect until Mutual of Omaha Insurance Company (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. Applicant acknowledges that no producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.

SECTION H

PLEASE READ AND SIGN - continued

Notice to Arkansas Residents Only: 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.

I have (a) read and understand the Authorization to Disclose Personal Information, Agreement and Fraud Warning Section; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: _____
City State Date

Signature of Proposed Insured Printed Name of Proposed Insured Date

Signature of Payor as shown on bank account Printed Name of Payor Date
(if Billing Mode is BSP and Payor is other than Proposed Insured)

17 **I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately.** Yes No
(If "No," please explain.) _____

I conducted said interview in person Yes No
(If "No," please explain.) _____

18 **I/We certify that I/we recorded completely and accurately the answers provided by the Proposed Insured(s), during an interview.** Yes No

(If "No," please explain.) _____

I conducted said interview in person Yes No
(If "No," please explain.) _____

19 I/WE authorize the fulfillment center representative to obtain health/medical information as may be necessary to complete any insurance application resulting from this lead submission, provided, however, that any item of information or question from the Proposed Insured(s) requiring the act or advice of a licensed insurance agent will be referred to me/us for action before the application can be completed.

Signature of Producer Producer's Printed Name Date

Office Name Office Address

Signature of Producer Producer's Printed Name Date

Office Name Office Address

SERFF Tracking Number: MUTM-126322971 State: Arkansas
 Filing Company: Mutual of Omaha Insurance Company State Tracking Number: 43822
 Company Tracking Number: JOANNE NAJDZIN
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Accident Medical Expense and Worker's Comp Riders - OML1M
 Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OML1M

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/28/2009	OML1M Arkansas Rates	OML1M	New		OML1M - Arkansas Rates.pdf

Mutual of Omaha Insurance Company
Omaha, Nebraska

Rider Form OML1M
Accident Medical Expense Benefits Rider
Annual Premiums by Benefit Amount
All Occupation Classes

<u>Maximum Benefit</u>	<u>All Ages</u>
500	47.70
1,000	88.36
1,500	112.15
2,000	129.02
2,500	142.11
3,000	152.81
3,500	161.85
4,000	169.69
4,500	176.60
5,000	182.78
5,500	188.37
6,000	193.47
6,500	198.17
7,000	202.52
7,500	206.56
8,000	210.35
8,500	213.91
9,000	217.26
9,500	220.43
10,000	223.44

SERFF Tracking Number: MUTM-126322971 State: Arkansas
 Filing Company: Mutual of Omaha Insurance Company State Tracking Number: 43822
 Company Tracking Number: JOANNE NAJDZIN
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other
 Product Name: Accident Medical Expense and Worker's Comp Riders - OMLIM
 Project Name/Number: Accident Medical Expense and Worker's Comp Riders/OMLIM

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/28/2009
Comments:			
Attachment:			
AR Read Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/28/2009
Comments:			
See Form Schedule tab for this Application form.			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/28/2009
Bypass Reason:	No Outline of Coverage is being submitted with this DI Rider filing.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Memo of Variable Material - Application	Approved-Closed	10/28/2009
Comments:			
Attachment:			
DI App Memo of Variability MA5952-03.pdf			

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.

Form

Description

Score

Date: _____



Daniel J. Kennelly
Vice President & Chief Compliance Officer

**Memorandum of Variability
Explanation of Variable Statements and Fields
For Mutual of Omaha Insurance Company
Application Form
MA5952-03**

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.

The large letters bracketed represent section numbers, **[B]** etc. The section numbers are subject to change based on the different sections of the application that may vary depending on marketing layout.

PAGE 1	
<i>Variable Statements/Fields</i>	<i>How or When Used</i>
1 [<input type="checkbox"/> ACCIDENT ONLY DISABILITY INSURANCE]	Either 1 or 2 will print depending on marketing layout.
2 [<input type="checkbox"/> SHORT-TERM DISABILITY INSURANCE <input type="checkbox"/> LONG TERM DISABILITY INSURANCE <input type="checkbox"/> BUSINESS OPERATING EXPENSE DISABILITY INSURANCE]	Ether 1 or 2 will print depending on marketing layout.
3 [E-mail address]	Will print depending on marketing layout.
4 [<input type="checkbox"/> Other (Please explain)]	Will print depending on marketing layout.
PAGE 2	
5 [SECTION [B] Complete only if applying for Accident Only Disability Insurance...]	Entire section will print or will be excluded depending on marketing layout.
6 [SECTION [C] Complete only if applying for SHORT-TERM DISABILITY...]	Entire section will print or will be excluded depending on marketing layout.
7 [Complete only if applying for SHORT-TERM DISABILITY [,] [or] LONG-TERM DISABILITY [or] BUSINESS OPERATING EXPENSE] Insurance.]	"Business Operating Expense" will print or will be excluded depending on marketing. The connective "or" and commas will print or not depending on whether "Business Operating Expense" is included.
PAGE 3	
8 [SECTION [D] Complete only if applying for BUSINESS OPERATING EXPENSE Insurance]	Entire section will print or will be excluded depending on marketing layout.
PAGE 4	
9 [ACCIDENT ONLY DISABILITY INSURANCE Monthly Benefit Amount \$ _____ Elimination Period: [<input type="checkbox"/> 0 Days] [<input type="checkbox"/> 7 Days] [<input type="checkbox"/> 14 Days] [<input type="checkbox"/> 30 Days] [<input type="checkbox"/> 60 Days] [<input type="checkbox"/> 90 Days] Benefit Period: [<input type="checkbox"/> 3 Months] [<input type="checkbox"/> 6 Months] [<input type="checkbox"/> 12 Months] [<input type="checkbox"/> 24 Months] Optional Riders: [<input type="checkbox"/> Hospital Confinement Accident Indemnity Benefit Rider [<input type="checkbox"/> \$125] [<input type="checkbox"/> \$250] [<input type="checkbox"/> \$350] [<input type="checkbox"/> \$500] [<input type="checkbox"/> Accident Medical Expense Rider Maximum Benefit: [<input type="checkbox"/> \$0,000] [<input type="checkbox"/> \$0,000] [<input type="checkbox"/> \$0,000] [<input type="checkbox"/> \$00,000]]]	The entire block is variable and within the block certain options are variable and will print depending on marketing and printing layout. For the Accident Medical Expense Rider, we will offer benefit amounts anywhere from \$1,000 to \$10,000, in increments of \$500. The Elimination Period is the initial number of days of total disability or partial disability that must pass before benefits are available. The Benefit Period is the maximum length of time total disability benefits or partial disability benefits are payable. For the optional riders, a combination will

	print depending on a range of benefits offered.
<p>10 [SHORT-TERM DISABILITY INSURANCE Monthly Benefit Amount \$ _____ Elimination Period [Accident/Sickness]: <input type="checkbox"/> 0/7 Days] <input type="checkbox"/> 7 Days] <input type="checkbox"/> 0/14 Days] <input type="checkbox"/> 14 Days] <input type="checkbox"/> 30 Days] <input type="checkbox"/> 60 Days] <input type="checkbox"/> 90 Days] Benefit Period: <input type="checkbox"/> 3 Months] <input type="checkbox"/> 6 Months] <input type="checkbox"/> 12 Months] <input type="checkbox"/> 24 Months] Optional Riders: <input type="checkbox"/> Return of Premium Benefit Rider (check one option) <input type="checkbox"/> 50%] <input type="checkbox"/> 80%]] <input type="checkbox"/> Hospital Confinement Indemnity Benefits Rider <input type="checkbox"/> \$125] <input type="checkbox"/> \$250] <input type="checkbox"/> \$350] <input type="checkbox"/> \$500]] <input type="checkbox"/> Critical Illness Benefits Rider (check one option) <input type="checkbox"/> \$5,000] <input type="checkbox"/> \$10,000] <input type="checkbox"/> \$15,000] <input type="checkbox"/> \$25,000]]]</p>	<p>The entire block is variable and within the block certain options are variable and will print depending on marketing and printing layout. The Elimination Period is the initial number of days of total disability or partial disability that must pass before benefits are available. The Benefit Period is the maximum length of time total disability benefits or partial disability benefits are payable. For the optional riders, a combination will print depending on a range of benefits offered.</p>
<p>11 [LONG-TERM DISABILITY INSURANCE Monthly Benefit Amount \$ _____ SIS Monthly Benefit Amount \$ _____ Elimination Period: <input type="checkbox"/> 60 Days] <input type="checkbox"/> 90 Days] <input type="checkbox"/> 180 Days] <input type="checkbox"/> 365 Days] Benefit Period: <input type="checkbox"/> 2 Years] <input type="checkbox"/> 5 Years] <input type="checkbox"/> 10 Years] <input type="checkbox"/> To Age 67] Optional Riders: <input type="checkbox"/> SIS (Social Insurance Supplement) Benefits Rider Do you have any dependent children age 17 or under? <input type="checkbox"/> yes or <input type="checkbox"/> No Are you covered under the Social Security Act? <input type="checkbox"/> yes or <input type="checkbox"/> No] <input type="checkbox"/> Return of Premium Benefit Rider (check one option) <input type="checkbox"/> 50%] <input type="checkbox"/> 80%]] <input type="checkbox"/> Hospital Confinement Indemnity Benefits Rider (check one option) <input type="checkbox"/> \$125] <input type="checkbox"/> \$250] <input type="checkbox"/> \$350] <input type="checkbox"/> \$500]] <input type="checkbox"/> Critical Illness Benefits Rider (check one option) <input type="checkbox"/> \$5,000] <input type="checkbox"/> \$10,000] <input type="checkbox"/> \$15,000] <input type="checkbox"/> \$25,000]] <input type="checkbox"/> Extended Proportionate Disability Benefits Rider] <input type="checkbox"/> Future Purchase Option (FIPO) Rider] <input type="checkbox"/> Extended Own.-Occ Disability Defin. Amend. Rider] <input type="checkbox"/> Non-Cancellable Amendment Rider] <input type="checkbox"/> Cost-of-Living Adjustment (COLA) Rider]]</p>	<p>The entire block is variable and within the block certain options are variable and will print depending on marketing and printing layout. The Elimination Period is the initial number of days of total disability or partial disability that must pass before benefits are available. The Benefit Period is the maximum length of time total disability benefits or partial disability benefits are payable. For the optional riders, a combination will print depending on a range of benefits offered.</p>
<p>12 [BUSINESS OPERATING EXPENSE DISABILITY INSURANCE Monthly Benefit Amount \$ _____ Elimination Period: <input type="checkbox"/> 30 Days] <input type="checkbox"/> 60 Days] <input type="checkbox"/> 90 Days] <input type="checkbox"/> 180 Days] <input type="checkbox"/> 365 Days] Benefit Period: <input type="checkbox"/> 12 Months] <input type="checkbox"/> 18 Months] [Optional Riders: <input type="checkbox"/> Accidental Death Rider Benefit Amt. \$ _____] <input type="checkbox"/> Accident Death and Dismemberment Rider Benefit Amt. \$ _____]]]</p>	<p>The entire block is variable and within the block certain options are variable and will print depending on marketing and printing layout. The Elimination Period is the initial number of days of total loss of time that must pass before benefits are payable. The Benefit Period is the maximum length of time total loss of time benefits are payable. The optional riders are variable and may or may not print. Or, a combination will print depending on a range of benefits offered.</p>
PAGE 5	

<p>13 [1.] [No Cash With App (Effective Date = Issue Date) <input type="checkbox"/> BSP]</p>	<p>The number for each billing option may vary depending on marketing layout. A combination of billing options will print if more than one payment method is provided depending on marketing layout.</p>
<p>14 [2.] <input type="checkbox"/> BSP [If BSP is selected, collect [2] months of premium.]</p>	<p>Will print depending on payment method offered. The number of months premium to be collected is variable.</p>
<p>15 [3.] [Payroll Deduction [(only available with Accident Only plan)] Add to Existing PRD - Group Number..... First Deduction Date..... Number of Deductions..... Effective Date.....]</p>	<p>Will print depending on payment method offered.</p>
<p>16 [4.] [Credit Card <input type="checkbox"/> By signing this application, I authorize the initial premium for this coverage to be automatically billed... ...Expiration Date ____/____] <input type="checkbox"/> By signing this application, I authorize the initial premium for this coverage to be automatically billed... ...Expiration Date ____/____] <input type="checkbox"/> Renewal Premiums: <input type="checkbox"/> BSP <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannual <input type="checkbox"/> Annual]]</p>	<p>A combination will print depending on payment method.</p>
PAGE 7	
<p>17 [I/We certify that during an interview with the Proposed Insured(s), I/We asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain.) _____ I conducted said interview in person <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain.) _____]</p>	<p>This certification will print when a paper application is used for an agent face-to-face interview or for a full e-application.</p>
<p>18 [I/We certify that I/we recorded completely and accurately the answers provided by the Proposed Insured(s), during an interview..... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain.) _____ I conducted said interview in person <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain.) _____]</p>	<p>This certification will print for a fulfillment center (aka drop ticked) process. This language allows us to have an interview that is not face-to-face and it allows for an agent to leave some of the questions blank.</p>
<p>19 [I/WE authorize the fulfillment center representative to obtain health/medical information as may be necessary to complete any insurance application...]</p>	<p>Will print depending on marketing layout.</p>