

SERFF Tracking Number: MUTM-126943472 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 47549
 Company Tracking Number: GILBERT BURKET
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: Individual Medicare Supplement Application - UA5910-03 Rev
 Project Name/Number: Individual Medicare Supplement Application/UA5910-03 Rev

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Individual Medicare Supplement SERFF Tr Num: MUTM-126943472 State: Arkansas

Application - UA5910-03 Rev

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 47549

Sub-TOI: MS08I.001 Plan A 2010

Co Tr Num: GILBERT BURKET

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Stephanie Fowler

Authors: Shelly Kaipust, Sofia Kuehn, Jan Serafini, Mary Gregg, Gilbert Burket, Krysia Gannon, Ellen Cochrane, Robyn Gonzales, Kristin Miller, Luther Mardock, Shirley McPhaul, Katie Tupper

Disposition Date: 01/12/2011

Date Submitted: 12/17/2010

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Individual Medicare Supplement Application

Status of Filing in Domicile:

Project Number: UA5910-03 Rev

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 01/12/2011

State Status Changed: 01/12/2011

Deemer Date:

Created By: Shelly Kaipust

Submitted By: Shelly Kaipust

Corresponding Filing Tracking Number:

Filing Description:

RE: United of Omaha Life Insurance Company

NAIC # 261-69868 FEIN 47-0322111

Individual Medicare Supplement Insurance

SERFF Tracking Number: MUTM-126943472 State: Arkansas
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Application UA5910-03 Rev

Enclosed for filing with your Department is the above-captioned Medicare supplement application which will be used to apply for our modernized 2010 Plan Medicare supplement policies. This application is new and will replace application UA5910-03, which was approved by your Department on April 25, 2008. This application will be used by our agency/brokerage and direct-to-consumer distribution channels.

This new application is identical to the application it replaces, except that there are two sections that have been changed. We have added specific instructions for applicants for Plan N. We have also inserted a section that will be used by those applying for Plan N as a replacement for existing coverage. It consists of a reduced number of questions which are drawn from our full list of previously approved health and medical questions. These will facilitate limited underwriting for those applying for Plan N as replacement coverage outside of an open-enrollment or guaranteed issue period.

We also request the use of voice and electronic signature capabilities with this application.

A Memorandum of Variable Material is attached which describes all variable aspects of this application.

Your consideration and approval of this filing will be most appreciated. If I may be of additional assistance as you complete your review, please do not hesitate to contact me.

Sincerely,

Katie Tupper
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-6904
Fax: 402-351-5298
E-mail: katie.tupper@mutualofomaha.com

Company and Contact

Filing Contact Information

Gilbert Burket, Product & Advertising Compliance Analyst	gilbert.burket@mutualofomaha.com
Mutual of Omaha	402-351-3707 [Phone]
Mutual of Omaha Plaza	402-351-5298 [FAX]

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Omaha, NE 68175

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: \$100.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$100.00	12/17/2010	43064173

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/12/2011	01/12/2011

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Disposition

Disposition Date: 01/12/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MUTM-126943472 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	AR Credit Card Cert	Accepted for Informational Purposes	Yes
Supporting Document	Memo of Variable Material	Accepted for Informational Purposes	Yes
Form	Individual Medicaare Supplement Application	Approved	Yes

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Form Schedule

Lead Form Number: UA5910-03 Rev

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/12/2011	UA5910-03 Rev	Application/ Enrollment Form	Individual Medicaare Supplement Application	Initial			UA5910-03 Rev (ar).pdf

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. 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		
14. (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-f)] [(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"/>
15. (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		
(e) Was this your first time in this type of Medicare plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) If "YES," with what company and what kind of policy? (List below)		

Applicant	Applicant B
Name of Company	Name of Company
Kind of Policy	Kind of Policy

(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank. START _____ / _____ / _____ END _____ / _____ / _____ Applicant Applicant B		
(c) Reason for termination/disenrollment? _____ / _____ Applicant Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ / _____ Applicant Applicant B		

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," (a) Will Medicaid pay your premiums for this Medicare supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	APPLICANT	APPLICANT B
	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"/>
6. Producers shall list any other health insurance policies they have sold to the applicant. (a) List policies sold which are still in force.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

16.

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies sold in the past five (5) years which are no longer in force.

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

If applying for plans other than Plan N:

- If you are applying during an Open Enrollment or Guaranteed Issue period, **SKIP SECTIONS 4 & 5 and GO TO SECTION 6.**
- If you are applying outside of an Open Enrollment or Guaranteed Issue period, **PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and then GO TO SECTION 6.**

If applying for Plan N:

- If you are applying during an Open Enrollment or Guaranteed Issue period, **SKIP SECTIONS 4 & 5 and GO TO SECTION 6.**
- If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and are **REPLACING** other coverage, **SKIP SECTION 4 and COMPLETE SECTIONS 5 & 6.**
- If you are applying for Plan N outside of an Open Enrollment or Guaranteed Issue period and **DO NOT** have a Medicare Supplement, Medicare Advantage or Employee Group Health Plan, **PLEASE ANSWER ALL QUESTIONS IN SECTION 4 and THEN GO TO SECTION 6.**

[(Please see the enclosed material for explanation of the Open Enrollment and Guaranteed Issue periods.)]

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for 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	

5. IF YOU ARE APPLYING FOR MEDICARE SUPPLEMENT PLAN N OUTSIDE OF AN OPEN ENROLLMENT OR GUARANTEED ISSUE PERIOD AND ARE REPLACING OTHER COVERAGE (including Medicare supplement, Medicare Advantage, group medical, etc.) – Please Answer These REQUIRED Questions. If you answer “YES” to any of the following questions 1-4, you will NOT be eligible for coverage.

	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 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"/>
3. Have you been diagnosed with any of the following?		
A. Kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. 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"/>
4. Within the past two years have you been treated for or been advised by a physician to have treatment for a heart attack; heart, coronary, or carotid artery disease; or heart rhythm disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. 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"/>
6. 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	

6. 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 Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
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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"/>	
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Relationship to Applicant:

First Name _____

Last Name _____

Street Address _____

City _____ State _____ ZIP _____

Policy/Certificate Number _____

7. METHOD OF PAYMENT

18.

For my initial payment:

I have enclosed \$ _____ for myself to pay for the first month.

I have enclosed \$ _____ for Applicant B (if applying) to pay for the first month.

1st month Total \$ _____

After that I and Applicant B (if applying) wish to be billed (select only one option):

Annually
 Semiannually
 Quarterly
 Monthly Direct

Monthly through Easy Pay Option (automatic deduction from your checking account.) I understand that my and Applicant B's (if applying) **renewal** premiums for this insurance will be withdrawn monthly through my checking account. Please complete the following:

- Please enclose a **voided** check with your signed application if the renewal premium is to be paid from a different checking account. Otherwise, your checking account information will be taken from the accompanying premium check for your initial payment.
- Please indicate when you prefer the monthly **renewal** premiums to be withdrawn from your account.
 Withdraw on the 1st of the month or Withdraw on the 15th of the month
- I authorize United of Omaha Life Insurance Company to withdraw monthly premiums from my checking account. It is understood and agreed that the payment will take place each month, automatically, with no further action on my part until this authorization is cancelled in writing or by calling [1-800-228-9999].

Applicant's Signature **X** _____ Date _____ / _____ / _____
Mo Day Yr

Applicant B's Signature **X** _____ Date _____ / _____ / _____
(if applying) Mo Day Yr

For my **initial** payment, [please select one of the following options:] [I select:]

[Credit Card – automatic deduction charged through my Visa or MasterCard account]

[Easy Pay Option – automatic deduction from your checking account]

For my **renewal** payments, [please select one of the following options:] [I select:]

[Credit Card – automatic deduction charged through the credit card selected above [(renewal credit card option not available if Easy Pay Option selected for initial payment)]

[Easy Pay Option – automatic deduction from your checking account [(renewal Easy Pay Option not available if credit card selected for initial payment)]

[Annually]

[Semiannually]

[Quarterly]

[Monthly]

Complete the following information [if you have selected the Credit Card and/or the Easy Pay Option]:

If you have selected Credit Card billing

I understand that my **initial [and/or renewal]** premium[(s)] for this insurance will be withdrawn through my credit card account.

_____ / _____
Cardholder Name Exp Date Account Number

Cardholder's Signature ✕ _____

Is the address the same as the Applicant? Yes No

If "No," please list address _____
Address City State Zip

Initial payment amount for: Myself \$ _____ Applicant B (if applying) \$ _____

I authorize United of Omaha Life Insurance Company to withdraw my **initial [and/or renewal]** premium[(s)] from my credit card. It is understood and agreed that the payment will take place each month, automatically, with no further action on my part until this authorization is cancelled in writing or by calling [1-800-228-9999].

Applicant's Signature ✕ _____ Date _____ / _____ / _____
Mo Day Yr

Applicant B's Signature ✕ _____ Date _____ / _____ / _____
(if applying) Mo Day Yr

If you have selected the Easy Pay Option

1. Please provide your bank name _____

Routing Number _____ Account Number _____

2. For **renewal** premiums, please indicate when you prefer the monthly premiums to be withdrawn from your account.

Withdraw on the 1st of the month or Withdraw on the 15th of the month

Initial payment amount for: Myself \$ _____ Applicant B (if applying) \$ _____

I authorize United of Omaha Life Insurance Company to withdraw my **initial [and/or renewal]** premium[(s)] from my checking account. It is understood and agreed that the payment will take place each month, automatically, with no further action on my part until this authorization is cancelled in writing or by calling [1-800-228-9999].

Applicant's Signature ✕ _____ Date _____ / _____ / _____
Mo Day Yr

Applicant B's Signature ✕ _____ Date _____ / _____ / _____
(if applying) Mo Day Yr

8. 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).

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.

Any person who, with intent to defraud or knowing 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.

22. Applicant's Signature _____ Date / /
Mo Day Yr

Applicant B's Signature _____ Date / /
Mo Day Yr

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

Dated at _____, on _____, _____
City State Month Day Year Applicant 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

SERFF Tracking Number: MUTM-126943472 State: Arkansas
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 Product Name: Individual Medicare Supplement Application - UA5910-03 Rev
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Accepted for Informational Purposes	01/12/2011
Comments:		
Attachment: AR Read Cert.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved	01/12/2011
Comments: See application under the Form Schedule tab.		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification		
Bypass Reason: Not applicable for this application filing.		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage		
Bypass Reason: Not applicable for this application filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: AR Credit Card Cert	Accepted for Informational Purposes	01/12/2011
Comments:		

SERFF Tracking Number: MUTM-126943472 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 47549
Company Tracking Number: GILBERT BURKET
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
Standard Plans 2010
Product Name: Individual Medicare Supplement Application - UA5910-03 Rev
Project Name/Number: Individual Medicare Supplement Application/UA5910-03 Rev

Attachment:

AR Credit Card Cert.pdf

	Item Status:	Status
Satisfied - Item: Memo of Variable Material	Accepted for Informational Purposes	Date: 01/12/2011

Comments:

Attachment:

UA5910-03 Rev AR Appl MOV.pdf

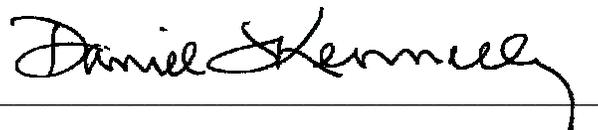
CERTIFICATION

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.

<u>Form</u>	<u>Description</u>	<u>Score</u>
UA5910-03 Rev	Medicare Supplement Application	40*

* when scored with the base policy

Date: 12/17/10



Daniel J. Kennelly
Vice President & Chief Compliance Officer

Arkansas Insurance Department

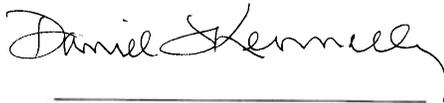
Mike Huckabee
Governor



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

12/17/2010
DATE

United of Omaha Life Insurance Company
COMPANY

CC-1

<i>Variable Statements/Fields</i>	<i>How or When Used</i>
PAGE 3	
14. [(d) If "Yes," have you received a copy of the replacement notice?...etc]	For use with our IDN and Agency Distribution channels.
15. [(b) If "Yes," have you received a copy of the replacement notice?...etc]	For use with our IDN and Agency Distribution channels.
PAGE 4	
16. [6. Producers shall list any other health insurance policies they have sold to the applicant...etc]	For use with our IDN and Agency Distribution channels.
PAGES 5 & 6	
17. [If you are applying for plans other than Plan N...etc]	For use with all distribution channels. This section will not print for solicitation during open enrollment or guaranteed issue.
Payment options, variables 18-23, may vary depending on the Marketing Campaign, therefore, only one of the following sections will print.	
PAGE 7	
18. [For my initial payment:...etc.]	Method of Payment option that may be used depending on the solicitation channel utilized.
PAGE 8	
19. [Send no money now!...etc.]	Method of Payment option that may be used depending on the solicitation channel utilized.
PAGE 9	
20. [For my initial payment, [please select one of the following options:]...etc.]	Method of Payment option that may be used depending on the solicitation channel utilized.
PAGE 10	
21. [For my initial payment, please select one of the following options:...etc.]	Method of Payment options that may be used depending on the solicitation channel utilized.
PAGE 11	
22. . [Applicant's Signature...etc. [Applicant B's Signature...etc.]	For use with our Direct to Consumer distribution channels.
23 [Dated at _____, on _____, ...etc.] City State Month Day	For use with our IDN and Agency Distribution channels.
LAST PAGE	
24. [ADDITIONAL INFORMATION: SECTION 4 Question #16... CON'T. HEALTH/MEDICAL QUESTIONS]	For use with all distribution channels. This section will not print for solicitation during open enrollment or guaranteed issue.
25. [SECTION FOR ADDITIONAL COMMENTS]	For use with all distribution channels.