

SERFF Tracking Number: MUTM-126969780 State: Arkansas
 Filing Company: United of Omaha Life Insurance Company State Tracking Number: 47633
 Company Tracking Number: KELLY KRUMWIED
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: Medicare Supplement Adverstising - UC7808
 Project Name/Number: Medicare Supplement Adverstising /UC7808

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Medicare Supplement Adverstising - UC7808 SERFF Tr Num: MUTM-126969780 State: Arkansas

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Filed-Closed State Tr Num: 47633

Sub-TOI: MS08I.001 Plan A 2010 Co Tr Num: KELLY KRUMWIED State Status: Filed-Closed
 Filing Type: Advertisement Reviewer(s): Stephanie Fowler
 Author: Kelly Krumwied Disposition Date: 01/26/2011
 Date Submitted: 01/04/2011 Disposition Status: Filed-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Medicare Supplement Adverstising

Status of Filing in Domicile:

Project Number: UC7808

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: 01/26/2011

State Status Changed: 01/26/2011

Deemer Date:

Created By: Kelly Krumwied

Submitted By: Kelly Krumwied

Corresponding Filing Tracking Number:

Filing Description:

Please see cover letter under supporting documentation tab.

Company and Contact

Filing Contact Information

Carly Cole, Product & Advertising Compliance carly.cole@mutualofomaha.com

Consultant

Mutual of Omaha 402-351-2476 [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: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$50.00	01/04/2011	43419688

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
	\$0.00	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed-Closed	Stephanie Fowler	01/26/2011	01/26/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Cover letter	Kelly Krumwied	01/05/2011	01/05/2011

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Disposition

Disposition Date: 01/26/2011

Implementation Date:

Status: Filed-Closed

Comment:

Rate data does NOT apply to filing.

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Amendment Letter

Submitted Date: 01/05/2011

Comments:

Please see revised cover letter. Thank you.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover letter

Comment:

AR letter app revised 01-05-11.pdf

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Form Schedule

Lead Form Number: UC7808

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Filed 01/26/2011	UC7808	Advertising	Instructional Advertising on Application	Initial			UC7808_brackets.pdf

6. 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, if you are covered under the employer or union-based group health plan. If you are covered under the employer or union-based group health plan, you may apply for Medicare Part D in certain circumstances, and later lose your employer or union-based group health plan. If you are covered under the 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).

Not For Ad Review

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.

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

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

UA5910-13 UNITED of OMAHA LIFE INSURANCE COMPANY • P.O. Box 3608 • Omaha, Nebraska 68103-3608 UAC5152_IA

NOTE: If selecting the Monthly Direct method of payment in Section 5, a \$2.00 monthly service fee will be applied.

If You Need Additional Help With Your Application – Please Call 1-800-707-1271.



UNITED OF OMAHA LIFE INSURANCE COMPANY
 A MUTUAL of OMAHA COMPANY

Please complete and mail this application with your first premium.

3

UC7808

Application For Medicare Supplement Coverage

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

1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Check The Plan You Prefer.	Check The Plan You Prefer.
<input type="checkbox"/> Plan A - UM20	<input type="checkbox"/> Plan A - UM20
<input type="checkbox"/> Plan F - UM23	<input type="checkbox"/> Plan F - UM23
<input type="checkbox"/> Plan G - UM24	<input type="checkbox"/> Plan G - UM24
<input type="checkbox"/> Plan M - UM30	<input type="checkbox"/> Plan M - UM30
<input type="checkbox"/> Plan N - UM31	<input type="checkbox"/> Plan N - UM31
If the above address is not your residence address, please state correct address _____	
Applicant	Applicant
Name (First/Middle/Last) _____	Name (First/Middle/Last) _____
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 Number _____	Social Security Number _____
Medicare Health Insurance Card Number (if known) _____	Medicare Health Insurance Card Number (if known) _____
E-mail Address _____	E-mail Address _____
Height _____ Ft _____ In Weight _____ Lbs	Height _____ Ft _____ In Weight _____ Lbs

Not For Ad Review

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.	APPLICANT	APPLICANT B
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "YES," what is your Part A effective date? _____ / _____ / _____ Applicant Applicant B		
If "NO," what is your eligibility date? _____ / _____ / _____ Applicant Applicant B		
2. Are you covered under Medicare Part B?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "YES," what is your Part B effective date? _____ / _____ / _____ Applicant Applicant B		
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?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "YES," indicate your effective date. _____ / _____ / _____ Applicant Applicant B		

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.

	APPLICANT	APPLICANT B
To the Best of Your Knowledge:		
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

Not For Ad Review

(b) If "YES," do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (NOTE: If the answer above is "YES" please attach proof of eligibility.)

(c) If "YES," indicate the name of the company and the plan you have.

If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-f) 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 / / / 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 No Yes No

(b) Reason for termination/disenrollment? /

Applicant Applicant B

(c) Planned date of termination/disenrollment? / / / / /

Applicant Applicant B

(d) Was this your first time in this type of Medicare plan? Yes No Yes No

(e) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes No Yes No

(f) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes No Yes No

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)

(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 <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/>	START <input type="text"/> / <input type="text"/> / <input type="text"/> END <input type="text"/> / <input type="text"/> / <input type="text"/>
Applicant	Applicant B
(c) Reason for termination/disenrollment? <input type="text"/> / <input type="text"/>	
Applicant	Applicant B
(d) Planned date of termination/disenrollment? <input type="text"/> / <input type="text"/>	
Applicant	Applicant B

	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,"	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

4. HOUSEHOLD DISCOUNT INFORMATION – Please Answer BOTH Questions 1 & 2 In This Section.

You may be eligible for a policy with a lower rate based on your answers to the statements in this section.	APPLICANT	APPLICANT B
1. 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 complete the information regarding Relationship to Applicant below, unless you AND Applicant B are applying for coverage on THIS application then do not complete the Relationship to Applicant information.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. 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 you answer "YES," to this question, please complete the information regarding Relationship to Applicant below.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Not For Ad Review

Relationship to Applicant:

First Name

Last Name

Street Address

City State ZIP

Policy/Certificate Number

5. METHOD OF PAYMENT

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 or savings account.) I understand that my and Applicant B's (if applying) **renewal** premiums for this insurance will be withdrawn monthly through my checking or savings account. Please complete the following:

1. Your checking account information will be taken from the accompanying premium check for your initial payment. If you wish for your **renewal** premium to be paid from a different checking account or from your savings account, please enclose a voided check or voided savings deposit slip with your signed application.

2. 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

3. I authorize United of Omaha Life Insurance Company to withdraw monthly premiums from my checking or savings 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.

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Supporting Document Schedules

	Item Status:	Status
Satisfied - Item: Cover letter	Filed	Date: 01/26/2011
Comments:		
Attachment:		
AR letter app revised 01-05-11.pdf		

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600



January 5, 2011

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

NAIC #: 261-69868
FEIN #: 47-0322111
United of Omaha Life Insurance Company
Direct Response Mail Advertising
Medicare Supplement Advertising
Instructional Advertising on Application: UC7808

Enclosed for review by your Department is a copy of the above-captioned advertising. The form is new and is not intended to replace any previously approved form. It will be used with appropriate approved forms in your state.

Advertisements UL5253_0810, UC7712_0810, UC7713_0810, UC7808, UE1465_0810 and UE1466_0810 comprise our new "Easy As 1, 2, 3" Medicare supplement marketing campaign. For your reference, advertisements UL5253_0810, UC7712_0810, UC7713_0810, UE1465_0810 and UE1466_0810 were approved by your Department on October 15, 2010, (please reference state tracking number 46962 or SERFF tracking number MUTM-126839086). Please note that the blue shaded box on the application form has been assigned form number UC7808 and submitted for review as the number "3" is part of the "Easy As 1, 2, 3" marketing concept.

The above advertisements will be used in a package with the following forms:

<u>Form Number</u>	<u>Date Approved By Your Department</u>
UA5910-03 (Application)	04-25-08
CP12, RP12.9.B-AR & DP2B (Outline of Coverage)	08-18-09
BC12 00-10 (Outline of Coverage)	11-19-09

Your notice of acceptance of this filing will be greatly appreciated.

Sincerely,

Product and Advertising Compliance
Corporate Compliance and Ethics

For questions, please contact Carly Cole
Phone: 402-351-2476; Fax: 402-351-5298
Email: advfilings@mutualofomaha.com

kk