Internal Tracking Code _____
Group # (if applicable) _____

MUTUAL of OMAHA

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Application for Individual Dental Insurance with Optional Vision Rider

A. Applicant Information

Name (First, Middle Initial, Last)	Phone Number Home Cell
Residence Address (Street, City, State, ZIP)	E-mail
Mailing Address (Street, City, State, ZIP) (if different from residence address)	Deliver Policy to Applicant Producer

Gender Male Female	Date of Birth	Social Security Number

B. Plan Information

Select Dental Benefit Plan	**Requested Effective Date** _____
Mutual Dental Preferred Annual Maximum $1,500 Mutual Dental Protection Annual Maximum $1,000	**Monthly Premium Rate for Dental $** _____
Optional Vision Rider (only available with Dental)	**Monthly Premium Rate for Vision $** _____
	Total Monthly Premium $ _____

C. Existing Coverage Information

Are you covered by any other dental or vision insurance? . . . . . Y N

If Yes, answer the following about this existing coverage:

Name of dental carrier(s) _____

Name of vision carrier(s) _____

Is the coverage you are applying for replacing existing dental insurance? . . . . . Y N

Is the coverage you are applying for replacing existing vision insurance? . . . . . Y N

D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief . Any incorrect or misleading answers may void this application and any issued policy . I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime .

ANY PERSON WHO, WITH THE 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 MAY HAVE VIOLATED STATE LAW .

I certify that I have read the completed application or had it read to me and I realize that any false statement or misrepresentation may result in loss of coverage under the policy .

I understand that there is a 12-month waiting period for Major dental services. If I am applying for the vision rider, I understand there is a 6-month waiting period for eye equipment.

✍ _____ _____

Applicant Signature Date Signed at City State

I/We certify that the applicant has read, or had read to him/her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy . I/We acknowledge that if the applicant is replacing coverage, I/We have provided a copy of the replacement notice, if applicable .

✍ _____ _____

Signature of Licensed Insurance Producer Date

_____ _____ _____%

Printed Name Agent Writing Number Comm . % Share

✍ _____ _____

Signature of Licensed Insurance Producer Date

_____ _____ _____%

Printed Name Agent Writing Number Comm . % Share