DNIS_____Auth # _____

Agent Writing # | | | | | | | | Group # (if applicable)_____Keyline _____

MUTUAL of OMAHA

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

How Did You Hear About Us?

Please select all that apply. Thank you for providing this helpful information.

- ☐ Agent/Broker/Producer
- ☐ Family Member/Friend
- ☐ Physician Referral
- ☐ Social Media
- ☐ Direct Mail
- ☐ Internet Search
- ☐ Radio
- ☐ TV

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): ☐ Plan A ☐ Plan D ☐ Plan G ☐ High Deductible Plan G ☐ Plan N ☐ **OR** If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: ☐ Plan C ☐ Plan F ☐ High Deductible Plan F ☐	Plan (select one): ☐ Plan A ☐ Plan D ☐ Plan G ☐ High Deductible Plan G ☐ Plan N **OR** If your Medicare Part A eligibility date is before 01/01/2020, these additional plans are available options: ☐ Plan C ☐ Plan F ☐ High Deductible Plan F
Requested Effective Date ___ / ___ / ____	Requested Effective Date ___ / ___ / ____
Deliver Policy to: ☐ Applicant A ☐ Producer	Deliver Policy to: ☐ Applicant A ☐ Producer

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone ___ – ___ – ____ (area code)	Home Phone ___ – ___ – ____ (area code)
E-mail Address	E-mail Address
Current Age _____ Date of Birth ___ / ___ / ____ (mo / day / yr)	Current Age _____ Date of Birth ___ / ___ / ____ (mo / day / yr)

B. Applicant Information (Continued)

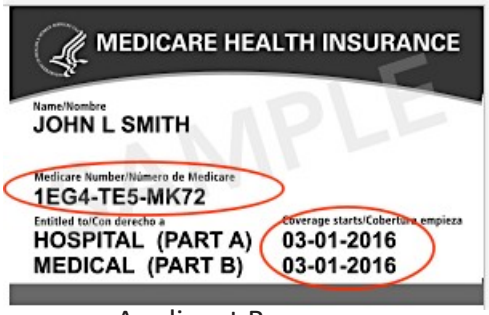
Applicant A	Applicant B
☐ Male ☐ Female	☐ Male ☐ Female
Social Security # ___ – ___ – ____	Social Security # ___ – ___ – ____
Height Ft ___ In ___ Weight Lbs ___	Height Ft ___ In ___ Weight Lbs ___
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Y ☐ N	Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? ☐ Y ☐ N

Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United of Omaha Life Insurance Company.

Applicant A	Applicant B
Receive statement online? ☐ Y ☐ N	Receive statement online? ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____	Medicare Part A Effective Date ___/___/____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/____
Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____	Medicare Part B Effective Date ___/___/____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/____

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	Applicant A	Applicant B
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months and who is age 60 or older; or (b) with whom you reside and to whom you are either married or in a civil union partnership?..	☐ Y ☐ N	☐ Y ☐ N
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.		

Name (First/Middle/Last)
Date of Birth
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

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

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
3. 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.)	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	☐ Y ☐ N	☐ Y ☐ N

Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this existing coverage:		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	☐ Y ☐ N	☐ Y ☐ N

(b) Indicate planned termination or disenrollment date..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

(c) With what company, and what plan do you have?

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	Applicant B
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past six months? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	☐ Y ☐ N	☐ Y ☐ N
If "YES," answer the following about this previous or existing coverage:		

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	☐ Y ☐ N	☐ Y ☐ N
(c) Planned date of termination/disenrollment?..... Applicant A ☐☐/☐☐/☐☐☐☐		
Applicant B ☐☐/☐☐/☐☐☐☐		
(d) Was this your first time in this type of Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	☐ Y ☐ N	☐ Y ☐ N
(f) Is your former Medicare supplement or Medicare Select policy/certificate still available?....	Y ☐ N	Y ☐ N
(g) Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?.....	☐ Y ☐ N	☐ Y ☐ N

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(h) Please indicate reason for termination/disenrollment:	Check box(s) below if applicable Applicant A	Applicant B
■ Your Medicare Advantage plan is leaving the Medicare program.....	☐	☐
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans..	☐	☐
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....	☐	☐
■ You moved out of the geographic service area of your Medicare Advantage plan.....	☐	☐
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....	☐	☐

■ Other: _____
Applicant A

_____
Applicant B

Please answer questions regarding other health insurance:

	Applicant A	Applicant B
6. Have you had coverage under any other health insurance within the past six months?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)	☐ Y ☐ N	☐ Y ☐ N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?
If you are still covered under this plan, leave "END" blank..... Applicant A START __/__/____

END __/__/____

Applicant B START __/__/____

END __/__/____

(b) Planned date of termination/disenrollment?. ..... Applicant A __/__/____

Applicant B __/__/____

(c) Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?.....	☐ Y ☐ N	☐ Y ☐ N
(d) Have you disenrolled from your current coverage voluntarily?.....	☐ Y ☐ N	☐ Y ☐ N

(e) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

(f) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you applying during an open enrollment period?		
(a) Did you turn age 65 in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N
(b) Did you enroll in Medicare Part B in the last six months?.....	☐ Y ☐ N	☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A __/__/____

Applicant B __/__/____

8. Are you applying during a guaranteed issue period?..... (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N

STOP IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

If you are applying during an open enrollment or guaranteed issue period: SKIP SECTIONS G & H and GO TO SECTION I.

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information

For all plans, answer questions 9-19. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
11. Have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	☐ Y ☐ N	☐ Y ☐ N
12. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Y ☐ N	☐ Y ☐ N
13. Do you have Osteoporosis, and as a result, experienced a fracture?	☐ Y ☐ N	☐ Y ☐ N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	☐ Y ☐ N	☐ Y ☐ N
15. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N

Part B: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement?	☐ Y ☐ N	☐ Y ☐ N
17. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)?	☐ Y ☐ N	☐ Y ☐ N
B. Had any changes in your medications within the past two years?	☐ Y ☐ N	☐ Y ☐ N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
19. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N

NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.

H. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
20. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	☐ Y ☐ N	☐ Y ☐ N

Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

I. Agreement and Authorization

IMPORTANT STATEMENTS

- 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 coverages.
- If you are age 65 or older, 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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. Agreement and Authorization (cont.)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED OF OMAHA LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Omaha Insurance Company, United World Life Insurance Company, Mutual of Omaha Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United of Omaha Life Insurance Company. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United of Omaha Life Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. 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.
I acknowledge receipt of A Guide to Health Insurance for People with Medicare (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

✍ Dated at _____, on ___/___/_____ _____
City State Month Day Year Applicant A's Signature

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

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J. Producer Comments (please attach a separate sheet if needed)

K. To be Completed by Producer

21. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s).

(a) List policies/certificates sold to the applicant(s) which are still in force.

Applicant A
Applicant B

(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant(s)..................................... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant(s).. ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. ____

____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

✍ ____
Signature of Licensed Producer Date

✍ ____
Signature of Licensed Producer Date

____
Printed Name

____
Printed Name

|_|_|_|_|_|_|_|
Agent Writing Number

|_|_|_|_|_|_|_|
Agent Writing Number

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

	Applicant A	Applicant B
Initial Premium Payment (Select option #1 or #2)		
✍ Initial premium amount (based on age at application date).....	$ _____.__	$ _____.__
1. Paper Check (submit signed check with application).....	☐	☐
(California collect only one month's premium at time of application)		
2. Automatic Bank Account Withdrawal.....	☐	☐
Ongoing Premium Payments (Select option #1a, #1b, or #2)		
1. I want my payments automatically withdrawn from my bank		
a. Choose the day payments will be deducted every month from your bank account.....	1st through the 28th or the last day of every month	1st through the 28th or the last day of every month
OR		
b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)	Week (1st, 2nd, 3rd, 4th, last) _____ Weekday (Mon, Tue, Wed, Thu, Fri) _____	Week (1st, 2nd, 3rd, 4th, last) _____ Weekday (Mon, Tue, Wed, Thu, Fri) _____
2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	every_____months Insert 3, 6, or 12	every_____months Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.

Part II. Payor Information

	Applicant A	Applicant B
1. Account Owner Name, if different than applicant's.....	_____	_____
2. If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.		
Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	☐	☐
Living Trust	☐	☐
Power of Attorney or legal guardian (documentation required)	☐	☐
Business owned by applicant or applicant's spouse	☐	☐

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