Group Life Insurance
Evidence of Insurability Form

Underwritten by: United of Omaha Life Insurance Company Home Office: Omaha, Nebraska

Section 1: Employer Information (Please print clearly. Required fields are marked with an asterisk (*).)

Employer's Name*	Group ID Number*
	G000 __ __ __ __

Street Address	Telephone

City*	State*	ZIP Code

Section 2: Employee Contact & Employment Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*	First Name*	Middle Name

Street Address*	E-mail Address

City*	State*	ZIP Code*	Telephone*

Full-Time Employment Date (MM/DD/YYYY)*	Job Title/Description*

Consent to E-mail Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this form via e-mail.

Section 3: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Part A – Complete if the Employee is Applying for Coverage

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*	Annual Salary*
		☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.	$

Part B – Complete if Your Eligible Dependent Spouse is Applying for Coverage

Last Name*	First Name*	MI

Birth Date (MM/DD/YYYY)*	State of Birth*	Gender*	Weight*	Height*
		☐ Female ☐ Male	_____ Pounds	____ Ft. ____ In.

Note: Use of the term "spouse" on this form refers to the person to whom you are legally married, or your domestic partner or equivalent, as recognized and allowed by federal law, or by state law in your state of residence.

Part C – Complete for Any Eligible Dependent Children Applying for Coverage

Last Name*	First Name*	Gender*	Birth Date (MM/DD/YYYY)*	Weight*	Height*
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.
		☐ Female ☐ Male		_____ Pounds	____ Ft. ____ In.

Section 4: Requested Coverage Amount (Please print clearly. Required fields are marked with an asterisk (*).)

	Employee (IF APPLICABLE)	Spouse (IF APPLICABLE)	Each Child (IF APPLICABLE)
(1) Current Amount of Insurance*			
(2) Additional Requested Amount*			
(3) Total Amount (1+2)*			

Employee Name: ______________________________________ SSN: _________________________

Last Name	First Name	Gender	Birth Date	Weight	Height
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.
		☐ Female ☐ Male		_______Pounds	_______Ft._______In.

Section 5: Health Information for Applicants (Please print clearly. A response is required for each health question.)

Part A – Health Questions

Health Question 1	**Response***
During the past seven years, have you or any dependent spouse or child applying for coverage ever been diagnosed by or received medical care from a medical professional for any of the following: ▪ Blood or circulatory disorder? ▪ Heart disorder? ▪ Paralysis? ▪ Mental, nervous or emotional disorder? ▪ Liver disorder? ▪ Cancer or tumor? ▪ Kidney or genitourinary disorder? ▪ Digestive disorder? ▪ Epilepsy or seizure? ▪ Lung or respiratory disorder? ▪ Diabetes? ▪ High blood pressure? ▪ Any disease of the immune system (except HIV)? ▪ Alcohol or drug abuse? ▪ Stroke?	☐ YES ☐ NO
Health Question 2	**Response***
During the past seven years, have you or any dependent spouse or child applying for coverage ever been diagnosed or treated by a member of the medical profession for having: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?	☐ YES ☐ NO
Health Question 3	**Response***
During the past five years, have you or any dependent spouse or child applying for coverage ever been prescribed medication by a medical professional or taken any medication requiring a prescription, other than for colds, flu or allergies? If yes, provide the diagnosis and the prescription below.	☐ YES ☐ NO
Health Question 4	**Response***
During the past five years, have you or any dependent spouse or child applying for coverage ever: ▪ Consulted a medical professional for any disease, disorder or condition not listed in questions 1 or 2? ▪ Been advised by member of the medical profession to have any diagnostic tests (except AIDS or HIV) or surgical operations? ▪ Been confined to any hospital or similar institution?	☐ YES ☐ NO

Part B – If you responded YES to any questions above, you must complete the following, as applicable:

Ques. #	Name of Applicant	Date of Occurrence (MM/DD/YYYY)	Date of Recovery (MM/DD/YYYY)	Condition, Injury, Diagnosis, Prescription and/or Findings of Exam

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

Section 6: Required Fraud Warnings – Please Read

Ohio: 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.

Section 7: Authorization to Disclose Personal Information & Application for Insurance

Part A – Definitions of Terms Used in Section 7

- **I** or **me** means each person signing below in Part C of Section 7, except where otherwise noted.
- **MIB, Inc.** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.
- **Personal Information** means information about me and/or any dependent child applying for coverage, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

Part B – Authorization to Disclose Personal Information

To MIB, Inc.: I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company ("Mutual of Omaha") or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to MIB, Inc. I understand that the Personal Information received by MIB, Inc. 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.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

Name(s) used for medical records (if different than the name(s) provided on this form): _____

_____

Part C – Application for Insurance

If I am an eligible employee applying for insurance, I apply for life insurance for me and any child identified in Section 3 of this form who is eligible for insurance. If I am an eligible spouse of the employee applying for insurance, I apply for life insurance for me. I understand that any insurance for a person applying for insurance in excess of the guaranteed issue amounts will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approves such person for such amounts. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I (the employee) permit my employer to deduct the premium contribution from my earnings for approved amounts of insurance. I understand that insurance for new or additional coverage does not begin until the employee's insurance certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha requests additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued.

I will retain a copy of this form with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE (REQUIRED AT ALL TIMES) _____ DATE __ __ __ __ __ __ __ __

SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE) _____ DATE __ __ __ __ __ __ __ __

Section 8: Form Submission

To help ensure efficient processing, mail the completed form to:

Attn: Group Underwriting Individual Selection
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS