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

Group Portability
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

A Guide for Successfully Completing the Mutual of Omaha Hospital Indemnity Continuation Request Form

Mutual of Omaha appreciates the opportunity to provide you with valuable hospital indemnity insurance protection for yourself and/or your loved ones. So that we can effectively process your request for hospital indemnity insurance under our hospital indemnity insurance continuation plan(s), we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

About the Form

The Hospital Indemnity Continuation Request Form is a request for insurance under Mutual of Omaha's hospital indemnity insurance continuation plan. Insurance under the plan is available to employees/members (hereafter referred to as "members") and/or eligible dependents when insurance under a Mutual of Omaha group hospital indemnity insurance plan (voluntary and/or basic) offered by a group ends.

A completed and signed form with initial premium payment MUST be mailed to Mutual of Omaha within 60 days after insurance has ceased under the group plan for your request to be considered.

All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

Section 1: Employer/Group Information
Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. The original date of hire or date of association for the member must also be provided.

Section 2: Applicant Information
Please provide all required applicant information. If the member is eligible to continue insurance, the member must be the applicant and elect insurance for dependents to be eligible. If the member is not eligible to continue insurance, the spouse (in the event of divorce or the employee's death, for example) can be the applicant and is eligible to continue hospital indemnity insurance for her/himself and dependents.

The applicant must be age 69* or less and be insured under the group hospital indemnity policy underwritten by us for at least six months to be eligible for insurance. Insurance under the portability plan terminates at age 70*.

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via email.

Section 3: Dependent Information & Dependent Eligibility
To be eligible to continue hospital indemnity insurance, dependents must have been insured under the group plan on the day insurance ended under the group plan.

If the member is eligible to continue insurance, the member must elect insurance for the dependents to be eligible.

In addition, a spouse must be age 69* or less and children must be age 25* or less to be eligible for insurance. Spouse insurance under the continuation plan terminates at age 70*, and child insurance terminates at age 26*.

Section 4: Continuation Insurance Election
Indicate the type of hospital indemnity insurance to be continued. If you were insured with the group for a plan that includes maternity, then you must continue with Plan 1: Maternity. If you were insured with the group for a plan that did not include maternity, then you must continue with Plan 2: Non-Maternity.

Section 5: Monthly Rates

These are the monthly rates that apply under the hospital indemnity continuation plan.

The applicant rates are based on the type of coverage tier and current age of the applicant. The four tiers are the Employee/Member only, Employee/Member + Spouse, Employee/Member + Child(ren), and Employee/Member + Family. For example, if a 53-year-old applicant is requesting hospital indemnity continuation for him/herself as well as his/her spouse and children, that would be the Employee/Member + Family tier and the 50-59 age band. If the applicant is the spouse and the spouse is applying for hospital indemnity continuation for him/herself and his/her children, then the age would be based on the spouse and they would choose the Employee/Member + Child(ren) tier.

The rates presented in Section 5 are used in Section 6 to determine premium for insurance under the continuation plan.

Section 6: Initial Premium Payment Calculation

Premium amounts must be calculated, and a billing mode must be selected.

Do the following to complete this section:

(a) Insert the appropriate monthly rate for the applicable plan type†. Rates are provided in Section 5.

(b) Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (2). To pay premium twice a year (semi-annually), insert a "6" into column (b). To pay premium annually, insert a "12" into column (b).

(c) Calculate the Premium Subtotal, by multiplying the Monthly Rate (a) by the Billing Frequency (b).

Section 7: Beneficiary Designation

You must designate a beneficiary for any hospital indemnity insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent hospital indemnity insurance.

If you wish to designate additional beneficiaries (beyond what space allows for on the form), please attach an additional sheet of paper to the form that includes the required information.

Section 8: Acknowledgement and Signature

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section and allows the form to be processed by Mutual of Omaha.

Section 9: Instructions

Follow the submission instructions to ensure your request is received by Mutual of Omaha. Be sure to include the Group ID Number on any payment and mail the request form and the payment to Mutual of Omaha as soon as possible after insurance ends under the group plan.

Remember, to be considered for insurance under the hospital indemnity insurance continuation plan, your request must be received within 60 days of the date insurance under the group plan ended.

Benefit Overview: The benefits payable are as follows:

Benefit	Amounts	
	Non-Maternity Plan	Maternity Plan
Hospital Admission	$1,000	$1,000
Daily Hospital Confinement	$100	$100
Intensive Care Unit (ICU) Admission	$2,000	$2,000
Daily Intensive Care Unit (ICU) Confinement	$200	$200
Health Screening Benefit	$50	$50
Daily Newborn Nursery Care Confinement	Not Included	$75

*The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, let's say you are 69 years old on October 1, 2022. Your Attained Age for the policy year (October 1, 2022 - September 30, 2023) is 69, even if your 70th birthday is in November. In this example, you are eligible for insurance under this plan until October 1, 2023.

†You may have had group hospital indemnity insurance under a voluntary hospital indemnity insurance plan or a basic hospital indemnity insurance plan from the group. Any plan must include a portability provision for the insurance available to you under the plan to be continued.

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

Group Portability
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (877) 466-8367

Hospital Indemnity Continuation Request Form

Please refer to "A Guide for Successfully Completing the Group Hospital Indemnity Continuation Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

IMPORTANT: This is a fixed indemnity policy, NOT health insurance. This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care. The payment you get isn't based on the size of your medical bill. There might be a limit on how much this policy will pay each year. This policy isn't a substitute for comprehensive health insurance. Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance? Visit HealthCare.gov or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options. To find out if you can get health insurance through your job, or a family member's job, contact the employer. **Questions about this policy?** For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments." If you have this policy through your job, or a family member's job, contact the employer.

Section 1: Group Information and Date of Hire/Association (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name*

Group ID Number*
G000 ___ ___ ___ ___

Date of Hire/Association (MM/DD/YYYY)*

Section 2: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name* | First Name* | MI

Street Address* | Email Address

City* | State* | ZIP Code* | Telephone*

Birth Date (MM/DD/YYYY)*†

Social Security Number*

Gender*
❑ Female ❑ Male

†*The applicant must be the Attained Age of 69 or less to be eligible for insurance.*

Consent to Email Correspondence
❑ Check this box if you consent to receiving future correspondence regarding this request via email.

Applicant Type*
❑ Employee/Member
❑ Spouse

Individuals for Whom Ported Insurance is Being Requested* (†Applies to employee/member applicants)
❑ Myself ❑ Myself & Spouse† ❑ Myself, Spouse & Child(ren)† ❑ Myself & Child(ren)

Reason for Request*
If you are an employee/member applicant, indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

❑ Status Change/Reduction in Hours — Date of Change: _____
❑ Employment/Association Terminated — Date of Termination: _____
❑ Plan Terminated by Group/Employer — Date of Termination: _____
❑ Employee/Member Retirement — Date of Retirement: _____

If you are a spouse applicant, please indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

❑ Divorce — Date of Divorce: _____
❑ Death of Employee/Member — Date of Death: _____
❑ Ineligible Due to Employee/Member Age — Date of Ineligibility: _____
❑ Ineligible Due to Employee/Member Active — Military Status; Date of Ineligibility: _____

Section 3: Dependent Information (Please print clearly. All fields are required for any dependents requesting insurance.)

Dependent Type	Last Name	First Name	MI	Date of Birth† (MM/DD/YYYY)	Gender
❑ Spouse ❑ Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male
Child					❑ Female ❑ Male

†A spouse must be the Attained Age of 69 or less and children must be the Attained Age of 25 or less to be eligible for insurance.

Section 4: Continuation Insurance Election

Plan Type† ❑ Plan 1: Maternity ❑ Plan 2: Non-Maternity

†You must continue insurance for the same plan type that you were insured under with the group. Please consult the employer/benefits administrator for the plan type.

Section 5: Monthly Rates

Plan 1: Maternity Plan

Age	18-29	30-39	40-49	50-59	60-64	65-69
Employee/Member	$19.93	$20.45	$15.97	$18.94	$31.50	$38.80
Employee/Member + Spouse	$40.07	$48.49	$41.28	$39.47	$64.58	$79.60
Employee/Member + Child(ren)	$28.61	$29.14	$25.34	$27.63	$40.18	$47.49
Employee/Member + Family	$57.66	$57.08	$47.02	$48.07	$73.18	$88.20

Plan 2: Non-Maternity Plan

Age	18-29	30-39	40-49	50-59	60-64	65-69
Employee/Member	$10.07	$12.03	$11.73	$18.94	$31.50	$38.80
Employee/Member + Spouse	$21.67	$26.19	$26.85	$39.47	$64.58	$79.60
Employee/Member + Child(ren)	$18.56	$20.53	$20.23	$27.63	$40.18	$47.49
Employee/Member + Family	$30.04	$34.56	$35.22	$48.07	$73.18	$88.20

Section 6: Initial Premium Payment Calculation

Initial Premium Payment Calculation

	(a) Monthly Rate	(b) Billing Frequency	(c) Premium Subtotal (a) X (b)
Applicant(s)			
		(d) Initial Premium Payment	$

Section 7: Beneficiary Designation (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Certain states are community property states. If you live in one of these states and you designate someone other than your spouse as a beneficiary, state law may require that your spouse consent to the designation. Community property states currently include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin. If you need to designate more beneficiaries than space will allow, please include this information on a separate piece of paper and submit it with this form, clearly stating your name.

Primary Beneficiary Designation

Last Name	First Name	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Telephone Number	Benefit Percent
						Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Telephone Number	Benefit Percent
						Percentage Total:	100%

Section 8: Acknowledgement and Signature

I understand that I may request insurance under the hospital indemnity continuation plan subject to the following:

- I understand that this insurance is subject to the rules of the policy governing the continuation plan.
- I understand that the individuals covered under the continuation plan must satisfy the continuation plan's requirements to be eligible for benefits and that payment of premium does not ensure eligibility for insurance. In the event that any premium is collected after eligibility for continued insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing the continuation plan.
- This request for insurance must be received by Mutual of Omaha within 60 days of the date that hospital indemnity insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha.
- Premium amounts may increase if any of the individuals insured under the plan enter a higher premium age category, or if continuation plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT _____ DATE _____/_____/_____

Section 9: Submission Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ended under the group plan. The form and payment must be received by Mutual of Omaha within 60 days of the date insurance under the group plan ended.
2) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.
3) Submit this form and payment to:
   Mutual of Omaha
   Policyowner Services
   P.O. Box 2147
   Omaha, NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha toll-free at (877) 466-8367.

Fraud Warnings

Required Fraud Warnings (State specific warnings apply to the resident of such state)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas/Kentucky/Louisiana/Maine/New Mexico/ Ohio/Tennessee: 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.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties as determined by a court of law.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico: Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virgin Islands: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal penalties.

Virginia: Any person who, with the intent to defraud or knowing that he 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.