

MUTUAL OF OMAHA INSURANCE COMPANY [ ]  
Mutual of Omaha Plaza  
Omaha, NE 68175



Mutual of Omaha

COMPANION LIFE INSURANCE COMPANY [ ]  
303 Merrick Road, Suite 503  
Lynbrook, NY 11563

Home Office Use Only  
Policy Number(s):  
\_\_\_\_\_

**Group Insurance Application**

**Applicant** (Full Legal Name) \_\_\_\_\_ (the Policyholder)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Requested Effective Date:** \_\_\_\_\_, subject to our acceptance of this application and payment of premium on or before such date.

**Coverage(s) being applied for:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Life                    | <input type="checkbox"/> AD&D                    | <input type="checkbox"/> Short Term Disability |
| <input type="checkbox"/> Life and Dependent Life | <input type="checkbox"/> AD&D and Dependent AD&D | <input type="checkbox"/> Long Term Disability  |

**Active at work requirement:** An employee must meet an Active at Work requirement to become insured. Will all proposed insureds meet the Active at Work requirement?  Yes  No If "No," please provide the name of the individual, date of birth, date of disability or confinement and nature of disability or confinement on a separate page.

Certain states have enacted legislation that requires insurers to provide specific coverage for people residing in their states. Do you have employees residing in or working in other states?  Yes  No

If "Yes," which states: \_\_\_\_\_

**Financial Risk** (If "Yes," to any part, please explain below)

- Has the applicant ever filed for bankruptcy?  Yes  No
- Does the applicant anticipate ceasing or materially reducing active business operations?  Yes  No

Explanation: \_\_\_\_\_

Application is made on the basis of the proposal, any available experience data and the information contained in this application.

The applicant signing below agrees to accept the terms and provisions of the Master Policy for the coverages applied for above. Insurance will become effective on the requested effective date shown above, unless we send written notice of a different effective date. If this application is not approved by an officer at the Home Office of the underwriting company, no insurance is in effect at any time and any advance payment received will be returned.

This application is submitted with the following advance payment \$ \_\_\_\_\_

**For AD&D and Disability Coverage - 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 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.

**For Applicant:**

**Name of Broker, agent and/or insurance agency soliciting this coverage:**

By \_\_\_\_\_  
(Signature)

\_\_\_\_\_

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)