

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



Mutual of Omaha
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:

- Life AD&D Short Term Disability
 Life and Dependent Life AD&D and Dependent AD&D 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 \$ _____

Fraud Warning - Any person who includes any false or misleading, information on an application for an insurance policy is subject to criminal and civil penalties.

For Applicant:

I, the applicant, certify that the statements made in this application are true and complete to the best of my knowledge and belief.

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

By _____
(Signature)

(Title)

(Date)