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

Mutual of Omaha appreciates the opportunity to provide you with valuable accident insurance protection for yourself and/or your loved ones. So that we can effectively process your request for accident insurance under our accident 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 Accident Continuation Request Form is a request for insurance under Mutual of Omaha's accident 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 accident 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 31 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 accident insurance for her/himself and dependents.

The applicant must be age 69* or less 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 accident insurance, a spouse 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 accident insurance to be continued. If you were insured with the group for a Non-Occupational plan, then you must continue with Plan 1: Non-Occupational. If you were insured with the group for a 24-Hour plan, then you must continue with Plan 2: 24-Hour.

Section 5: Monthly Rates

These are the monthly rates that apply under the accident continuation plan.

The applicant rates are based on the type of coverage tier. The four tiers are the Employee/Member only, Employee/Member + Spouse, Employee/Member + Child(ren), and Employee/Member + Family. For instance, if the applicant is requesting accident continuation for him/herself as well as his/her spouse and children, that would be the Employee/Member + Family tier. If the applicant was the spouse and the spouse was applying for accident continuation for him/herself and his/her children, that would be 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. Add together the monthly rates from any eligible voluntary and basic accident plans, if needed.[†]w

(b) Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (2). To pay premium twice a year (semiannually), 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).

(d) Calculate the Initial Premium Payment, by adding the $5.00 Billing Fee to the Premium Subtotal (c).

SECTION 7: BENEFICIARY DESIGNATION

You must designate a beneficiary for any accident insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent accident 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 accident insurance continuation plan, your request must be received within 31 days of the date insurance under the group plan ended.

[*]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, 2014. Your Attained Age for the policy year (October 1, 2014 – September 30, 2015) is 69, even if your 70th birthday is in November. In this example, you are eligible for insurance under this plan until September 30, 2015.

[†]You may have had group accident insurance under a voluntary accident insurance plan, a basic (employer-paid) accident insurance plan, or both, from the group. Any plan must include a portability or conversion provision for the insurance available to you under the plan to be continued. It may be possible that the insurance you had under a voluntary plan can be continued, but the insurance you had under a basic (employer-paid) plan cannot be continued, for example. Please consult the certificate for each group plan or the employer/benefits administrator to determine if continuation is available.

Accident Continuation Insurance

BENEFIT INFORMATION

This insurance offers financial protection by paying a cash benefit if an insured person is injured as the result of a covered accident. Accident continuation insurance is available when insurance under a group accident insurance plan ends.

If you were insured with a group for a Non-Occupational plan, then Plan 1: Non-Occupational is the continuation plan available to you. If you were insured with a group for a 24-Hour plan, then Plan 2: 24-Hour is the continuation plan available to you.

Plan Information	Benefit Amounts	
	Plan 1: Non-Occupational (Off-job only)	**Plan 2: 24-Hour (On and off-job)**
Annual Benefit Maximum (ABM)	$10,000	$10,000
Benefits		
	Plan 1: Non-Occupational (Off-job only)	**Plan 2: 24-Hour (On and off-job)**
Initial Care & Emergency[1] – Most treatment/service required within 72 hours of accident; Once per accident per insured person		
Emergency Room	$150	$150
Urgent Care Center	$100	$100
Initial Physician Office Visit	$75	$75
Ambulance	Up to $1,000	Up to $1,000
Specified Injuries[1,2]		
Fractures (Surgical / Non-surgical)	Up to $5,000 / Up to $2,500	Up to $5,000 / Up to $2,500
Dislocations (Surgical / Non-surgical)	Up to $6,000 / Up to $3,000	Up to $6,000 / Up to $3,000
Lacerations	Up to $600	Up to $600
Burns	Up to $10,000	Up to $10,000
Dental	Up to $200	Up to $200
Hospital, Surgical & Diagnostic[1,3]		
Admission	$1,000	$1,000
Daily Confinement (Up to 365 days per accident)	$200 per day	$200 per day
ICU Confinement (Up to 15 days per accident)	$400 per day	$400 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$100 per day	$100 per day
Surgical	Up to $1,500	Up to $1,500
Diagnostic	Up to $200	Up to $200
Follow-Up Care[1] – Treatment/service required within 365 days of accident; Medical device is once per accident per insured person		
Physician Follow-Up Office Visit	$75; Up to 2 per accident	$75; Up to 2 per accident
Therapy Services	$25; Up to 6 per accident	$25; Up to 6 per accident
Medical Device	$100	$100
Prosthetic Device(s)	$750; Up to 2 per accident	$750; Up to 2 per accident
Additional Benefits[1] – Benefits are payable within 365 days of accident		
Transportation (Up to 3 trips per accident)	$300 per trip	$300 per trip
Lodging (Up to 30 nights per accident)	$125 per night	$125 per night
Childcare (Up to 30 days per accident)	$20 per day	$20 per day
Catastrophic Benefits[1] – Benefits are payable within 365 days of accident; Once per accident per insured person		
Principal Sum (PS)	You: $25,000 Spouse: $10,000 Child(ren): $5,000	You: $25,000 Spouse: $10,000 Child(ren): $5,000
Common Carrier Accidental Death	300% of PS	300% of PS
Transportation of Remains	Up to $5,000	Up to $5,000
Dismemberment & Paralysis	Up to 100% of PS	Up to 100% of PS
Reasonable Modifications	Up to 10% of PS	Up to 10% of PS
Coma	50% of PS	50% of PS

[1]Additional limitations apply as described in the certificate.
[2]Fractures and dislocations require treatment within 90 days of accident, burns and lacerations within 72 hours of an accident, and dental care within 30 days. If an insured person sustains both a fracture and dislocation as the result of the same accident, the maximum amount payable is up to 200% of the amount payable for the injury with the highest applicable benefit amount.
[3]Daily confinement must begin with 90 days of accident and ICU confinement within 30 days. Surgical treatment time frames vary. If applicable, diagnostic services must be received within 30 days of accident. Except for admission and confinement benefits, most benefits are payable once per accident per insured person. If any surgery occurs concurrently with an open reduction for a fracture or dislocation of the same bone or joint as a result of the same accident, only the highest applicable benefit is payable.

FREQUENTLY ASKED QUESTIONS

Who is eligible for this insurance? – To be eligible for this insurance, you and your spouse (if applicable) must have been insured under the group plan on the day accident insurance under that plan ended. In addition:

- You and your spouse must be under age 70, and any child(ren) must be under age 26
- You and your dependent(s) must have major medical insurance, or basic hospital and basic medical insurance

Can I insure my domestic partner or civil union partner? – Any reference to "spouse" includes your domestic partner, civil union partner, reciprocal beneficiary or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in your jurisdiction of residence.

What is the "Annual Benefit Maximum (ABM)?" – An ABM allows this insurance to be more affordable, by "capping" the amount of benefits payable under the plan each calendar year while still helping to cover the expenses your health insurance plan doesn't (such as deductibles and copays). A new ABM is available each calendar year.

When does this insurance end? – Insurance will end on the last day of the month in which an insured person no longer satisfies the applicable eligibility conditions, or when you reach the age of 70. Additional circumstances under which insurance will end are described in the certificate.

Are there any exclusions or limitations? – The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy. The accident definitions, exclusions and limitations are detailed in the certificate.

How much does it cost and how do I pay for it? – The amounts shown below are monthly amounts. You may elect insurance for you only, or for your family.

Coverage Tier	Premium Amount	
	Plan 1	Plan 2
Employee/Member	$12.78	$16.77
Employee/Member + Spouse	$18.45	$23.07
Employee/Member + Child(ren)	$22.94	$26.38
Employee/Member + Family	$29.89	$34.32

Premiums must be paid to Mutual of Omaha at the billing frequency requested on the Accident Continuation Request Form. You will receive a bill from Mutual of Omaha in advance of each premium due date.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Accident insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010. This policy provides accident insurance only. It does not provide basic hospital, basic medical or major medical insurance. It is not a Medicare supplement policy. The insurance is designed to pay you a fixed dollar amount regardless of the amount any provider charges.

Accident Continuation Request Form

Mutual of Omaha

Premium Services
Underwritten by: United of Omaha Life Insurance Company

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

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*	Date of Hire/Association (MM/DD/YYYY)*
	G000 __ __ __ __	

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*	Individuals for Whom Continued Insurance is Being Requested* (†Applies to employee/member applicants)
☐ Employee/Member ☐ Spouse	☐ 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 spouse 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 Requested†

☐ Plan 1: Non-Occupational ☐ Plan 2: 24-Hour

†*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

Coverage Tier	Plan 1: Non-Occupational	Plan 2: 24-Hour
Employee/Member	$12.78	$16.77
Employee/Member + Spouse	$18.45	$23.07
Employee/Member + Child(ren)	$22.94	$26.38
Employee/Member + Family	$29.89	$34.32

Section 6: Initial Premium Payment Calculation

Initial Premium Payment Calculation

	(a) Monthly Rate	(b) Billing Frequency	(c) Premium Subtotal (a) X (b)
Applicant(s)			
		Billing Fee	+ $5.00
		(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 accident 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 31 days of the date that accident 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 31 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
   PO 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

United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza • Omaha, NE 68175-0001
Phone (800) 948-9478 (toll-free) • www.mutualofomaha.com/customer-service

Please review the specific fraud warning for your place of residence prior to signing the attached form or application.

All Other States: 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/Maine/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 a false or fraudulent 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: 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

Kentucky: 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.

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

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.

Massachusetts/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.

New Jersey: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal 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.

North Carolina/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, may have committed 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.

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.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.