United World Life Application Packet

Thank you for your interest in the United World Life Medicare Supplement plan!

This application packet provides you with a link to the Online Application to submit your application directly to United World Life directions about how to access a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Omaha Insurance Company. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Online Application
Download Policy Outline (.pdf)
For a printable application: Click here

Our website: https://medicare-oregon.com
If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Underwritten by
United World Life Insurance Company
A Mutual of Omaha Company

3316 Farnam Street
Omaha, Nebraska 68175

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

OREGON

Try it today on Sales Professional Access
or contact Sales Support.

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12/15/2021

UNITED WORLD LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	PLAN A	PLAN B	PLAN D	**PLAN G**	**G[1]**	PLAN K	PLAN L	PLAN M	**PLAN N**	PLAN C	**PLAN F**	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints each year)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2022[2]						$6,620[2]	$3,310[2]					

[1]Plans F and G also have a high deductible option which require first paying a plan deductible $2,490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit. The annual OOP limits are determined in accordance with section 1882(w)(2) of the Social Security Act. That provision prescribed an OOP limit for 2006 of $4,000 for Plan K and $2,000 for Plan L and directed that these amounts increase each subsequent year by an appropriate inflation adjustment specified by the Secretary of the United States Department of Health & Human Services. For 2019 the calculation of the OOP limits is based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program developed by CMS as published with the announcement of Calendar Year (CY) 2018 and CY 2019 Medicare Advantage (MA) payment rates.

[3]Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY NON-TOBACCO PREMIUMS*
ZIP CODES: 970, 972-977, 979

FEMALE						MALE				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
138.13	199.82	142.41	44.23	108.62	**Thru 64**	153.33	221.80	158.07	49.09	120.57
138.13	199.82	142.41	44.23	108.62	**65**	153.33	221.80	158.07	49.09	120.57
138.13	199.82	142.41	44.23	108.62	**66**	153.33	221.80	158.07	49.09	120.57
138.13	199.82	142.41	44.23	108.62	**67**	153.33	221.80	158.07	49.09	120.57
143.66	207.80	148.11	47.16	112.97	**68**	159.46	230.67	164.40	52.35	125.39
149.19	215.80	153.80	49.01	117.32	**69**	165.60	239.54	170.72	54.40	130.22
154.72	223.79	159.50	50.84	121.66	**70**	171.73	248.41	177.04	56.44	135.04
160.24	231.79	165.19	52.89	126.00	**71**	177.87	257.28	183.37	58.71	139.86
165.76	239.78	170.89	54.99	130.35	**72**	184.00	266.15	189.69	61.04	144.69
172.72	250.33	178.06	57.11	136.34	**73**	191.72	277.86	197.66	63.39	151.34
179.68	260.88	185.24	59.26	142.34	**74**	199.45	289.57	205.62	65.77	158.00
186.65	271.43	192.42	61.29	148.33	**75**	207.18	301.29	213.58	68.03	164.65
193.61	281.98	199.60	63.39	154.33	**76**	214.91	313.00	221.56	70.36	171.31
200.57	292.53	206.78	65.14	160.32	**77**	222.63	324.71	229.52	72.31	177.96
207.79	302.47	214.22	66.90	166.10	**78**	230.65	335.75	237.78	74.26	184.37
215.01	312.42	221.66	68.79	171.87	**79**	238.66	346.79	246.04	76.36	190.78
222.23	322.36	229.11	70.68	177.64	**80**	246.68	357.83	254.31	78.45	197.19
229.46	332.31	236.55	73.09	183.42	**81**	254.69	368.87	262.57	81.12	203.59
236.67	342.26	243.99	75.50	189.19	**82**	262.71	379.91	270.83	83.80	210.00
245.19	355.26	252.78	77.91	196.00	**83**	272.17	394.35	280.58	86.48	217.56
253.71	368.27	261.56	80.31	202.81	**84**	281.63	408.78	290.34	89.14	225.12
262.23	381.28	270.34	82.70	209.62	**85**	291.09	423.22	300.09	91.79	232.68
270.76	394.28	279.13	85.05	216.43	**86**	300.54	437.65	309.83	94.41	240.24
279.28	407.29	287.92	87.40	223.24	**87**	309.99	452.09	319.58	97.01	247.80
284.86	415.43	293.67	89.70	227.70	**88**	316.20	461.13	325.98	99.57	252.75
290.56	423.75	299.55	91.97	232.26	**89**	322.52	470.36	332.49	102.09	257.81
296.37	432.22	305.53	94.17	236.91	**90**	328.97	479.76	339.14	104.53	262.96
302.30	440.86	311.65	96.54	241.64	**91**	335.55	489.36	345.93	107.15	268.22
308.34	449.68	317.88	98.95	246.48	**92**	342.26	499.14	352.85	109.83	273.59
314.51	458.68	324.24	101.43	251.41	**93**	349.11	509.13	359.90	112.58	279.06
320.80	467.85	330.72	103.97	256.44	**94**	356.09	519.31	367.10	115.40	284.64
327.22	477.20	337.33	106.57	261.56	**95**	363.21	529.69	374.44	118.29	290.34
333.76	486.75	344.08	109.24	266.79	**96**	370.47	540.29	381.93	121.25	296.14
340.43	496.48	350.96	111.98	272.13	**97**	377.88	551.10	389.57	124.30	302.07
347.24	506.41	357.98	114.78	277.57	**98**	385.44	562.11	397.36	127.41	308.11
354.19	516.54	365.14	117.66	283.12	**99+**	393.15	573.36	405.31	130.60	314.27

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

MONTHLY TOBACCO PREMIUMS*
ZIP CODES: 970, 972-977, 979

FEMALE						MALE				
Plan A WM20	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**	**Attained Age**	**Plan A WM20**	**Plan F WM24**	**Plan G WM25**	**Plan High G WM36**	**Plan N WM35**
158.78	229.67	163.69	50.84	124.85	**Thru 64**	176.24	254.94	181.69	56.43	138.59
158.78	229.67	163.69	50.84	124.85	**65**	176.24	254.94	181.69	56.43	138.59
158.78	229.67	163.69	50.84	124.85	**66**	176.24	254.94	181.69	56.43	138.59
158.78	229.67	163.69	50.84	124.85	**67**	176.24	254.94	181.69	56.43	138.59
165.13	238.86	170.24	54.21	129.85	**68**	183.29	265.14	188.96	60.17	144.13
171.48	248.05	176.78	56.33	134.85	**69**	190.34	275.33	196.22	62.53	149.68
177.84	257.23	183.33	58.44	139.84	**70**	197.39	285.53	203.50	64.87	155.22
184.18	266.42	189.87	60.79	144.83	**71**	204.44	295.72	210.77	67.48	160.76
190.53	275.60	196.42	63.21	149.83	**72**	211.49	305.92	218.03	70.16	166.31
198.53	287.74	204.67	65.64	156.72	**73**	220.37	319.38	227.19	72.86	173.96
206.53	299.86	212.92	68.11	163.61	**74**	229.26	332.84	236.35	75.60	181.61
214.54	311.99	221.18	70.45	170.50	**75**	238.13	346.31	245.50	78.19	189.25
222.54	324.11	229.42	72.86	177.39	**76**	247.02	359.77	254.66	80.88	196.90
230.54	336.24	237.67	74.87	184.28	**77**	255.90	373.23	263.82	83.11	204.55
238.84	347.67	246.23	76.90	190.92	**78**	265.11	385.91	273.31	85.36	211.92
247.14	359.10	254.79	79.07	197.55	**79**	274.33	398.61	282.81	87.78	219.29
255.44	370.53	263.34	81.24	204.19	**80**	283.54	411.30	292.31	90.18	226.65
263.74	381.97	271.90	84.01	210.82	**81**	292.75	423.98	301.80	93.24	234.02
272.03	393.40	280.45	86.78	217.46	**82**	301.96	436.68	311.30	96.32	241.37
281.83	408.35	290.55	89.56	225.29	**83**	312.83	453.27	322.51	99.40	250.07
291.62	423.30	300.64	92.31	233.11	**84**	323.71	469.86	333.72	102.46	258.76
301.42	438.25	310.74	95.05	240.94	**85**	334.58	486.46	344.93	105.51	267.44
311.21	453.20	320.84	97.76	248.77	**86**	345.44	503.05	356.13	108.52	276.14
321.01	468.15	330.94	100.46	256.60	**87**	356.31	519.64	367.34	111.51	284.82
327.43	477.51	337.55	103.11	261.73	**88**	363.45	530.04	374.69	114.44	290.52
333.98	487.06	344.30	105.71	266.97	**89**	370.71	540.64	382.18	117.34	296.33
340.65	496.80	351.19	108.24	272.31	**90**	378.13	551.45	389.82	120.15	302.26
347.47	506.74	358.22	110.96	277.75	**91**	385.69	562.48	397.62	123.17	308.30
354.42	516.88	365.38	113.73	283.31	**92**	393.40	573.73	405.57	126.24	314.47
361.50	527.21	372.69	116.58	288.97	**93**	401.27	585.20	413.68	129.41	320.76
368.74	537.75	380.14	119.50	294.75	**94**	409.30	596.91	421.96	132.64	327.17
376.11	548.51	387.74	122.49	300.64	**95**	417.48	608.84	430.39	135.97	333.72
383.64	559.48	395.50	125.56	306.66	**96**	425.83	621.03	439.00	139.37	340.39
391.30	570.67	403.41	128.71	312.79	**97**	434.35	633.44	447.78	142.87	347.20
399.13	582.08	411.47	131.93	319.05	**98**	443.04	646.11	456.74	146.45	354.15
407.11	593.72	419.71	135.24	325.43	**99+**	451.89	659.04	465.87	150.12	361.23

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MONTHLY NON-TOBACCO PREMIUMS*
ZIP CODES: 971, 978

FEMALE						MALE				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
140.03	202.55	144.36	44.83	110.11	**Thru 64**	155.43	224.83	160.24	49.77	122.23
140.03	202.55	144.36	44.83	110.11	**65**	155.43	224.83	160.24	49.77	122.23
140.03	202.55	144.36	44.83	110.11	**66**	155.43	224.83	160.24	49.77	122.23
140.03	202.55	144.36	44.83	110.11	**67**	155.43	224.83	160.24	49.77	122.23
145.63	210.65	150.13	47.81	114.52	**68**	161.65	233.83	166.65	53.07	127.11
151.23	218.76	155.91	49.68	118.92	**69**	167.86	242.82	173.05	55.15	132.01
156.84	226.86	161.68	51.54	123.33	**70**	174.08	251.82	179.47	57.21	136.89
162.43	234.96	167.45	53.62	127.73	**71**	180.30	260.80	185.88	59.51	141.78
168.03	243.06	173.23	55.75	132.13	**72**	186.52	269.80	192.28	61.88	146.67
175.09	253.76	180.50	57.89	138.21	**73**	194.35	281.67	200.36	64.26	153.42
182.14	264.45	187.78	60.07	144.29	**74**	202.19	293.54	208.44	66.67	160.17
189.21	275.15	195.06	62.13	150.37	**75**	210.01	305.41	216.51	68.96	166.91
196.26	285.84	202.33	64.26	156.44	**76**	217.85	317.28	224.59	71.33	173.65
203.32	296.53	209.61	66.03	162.52	**77**	225.68	329.16	232.66	73.30	180.40
210.64	306.62	217.15	67.82	168.37	**78**	233.81	340.35	241.04	75.28	186.90
217.96	316.70	224.70	69.74	174.23	**79**	241.93	351.54	249.41	77.41	193.39
225.28	326.78	232.24	71.65	180.08	**80**	250.06	362.73	257.79	79.53	199.89
232.60	336.86	239.79	74.09	185.93	**81**	258.18	373.92	266.17	82.23	206.38
239.91	346.95	247.34	76.54	191.78	**82**	266.31	385.12	274.54	84.95	212.87
248.55	360.13	256.24	78.98	198.68	**83**	275.89	399.75	284.43	87.67	220.54
257.19	373.31	265.14	81.41	205.59	**84**	285.49	414.38	294.31	90.36	228.20
265.83	386.50	274.05	83.83	212.49	**85**	295.07	429.02	304.20	93.05	235.86
274.47	399.68	282.95	86.22	219.39	**86**	304.65	443.65	314.08	95.71	243.53
283.10	412.87	291.86	88.59	226.30	**87**	314.24	458.28	323.96	98.34	251.19
288.76	421.12	297.69	90.93	230.82	**88**	320.53	467.45	330.44	100.93	256.21
294.54	429.55	303.65	93.23	235.44	**89**	326.93	476.80	337.05	103.48	261.34
300.43	438.14	309.72	95.46	240.15	**90**	333.48	486.33	343.79	105.96	266.57
306.44	446.90	315.92	97.86	244.95	**91**	340.15	496.06	350.67	108.62	271.90
312.57	455.84	322.24	100.30	249.85	**92**	346.95	505.98	357.68	111.33	277.34
318.82	464.96	328.68	102.82	254.85	**93**	353.89	516.10	364.84	114.13	282.89
325.20	474.26	335.25	105.39	259.95	**94**	360.97	526.42	372.13	116.98	288.54
331.70	483.74	341.95	108.03	265.14	**95**	368.18	536.95	379.57	119.91	294.31
338.34	493.42	348.80	110.73	270.45	**96**	375.55	547.69	387.16	122.91	300.20
345.10	503.28	355.77	113.51	275.86	**97**	383.06	558.64	394.91	126.00	306.20
352.00	513.35	362.88	116.35	281.37	**98**	390.72	569.81	402.81	129.15	312.33
359.04	523.62	370.15	119.27	287.00	**99+**	398.53	581.22	410.86	132.39	318.57

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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MONTHLY TOBACCO PREMIUMS*
ZIP CODES: 971, 978

FEMALE						MALE				
Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35	Attained Age	Plan A WM20	Plan F WM24	Plan G WM25	Plan High G WM36	Plan N WM35
160.95	232.82	165.93	51.53	126.56	**Thru 64**	178.65	258.43	184.18	57.20	140.49
160.95	232.82	165.93	51.53	126.56	**65**	178.65	258.43	184.18	57.20	140.49
160.95	232.82	165.93	51.53	126.56	**66**	178.65	258.43	184.18	57.20	140.49
160.95	232.82	165.93	51.53	126.56	**67**	178.65	258.43	184.18	57.20	140.49
167.39	242.13	172.57	54.95	131.63	**68**	185.80	268.77	191.55	61.00	146.11
173.83	251.45	179.21	57.11	136.69	**69**	192.95	279.11	198.91	63.39	151.73
180.27	260.75	185.84	59.24	141.75	**70**	200.10	289.44	206.28	65.76	157.35
186.70	270.07	192.47	61.63	146.82	**71**	207.24	299.77	213.65	68.41	162.96
193.14	279.38	199.11	64.08	151.88	**72**	214.39	310.11	221.02	71.12	168.59
201.25	291.68	207.47	66.54	158.86	**73**	223.39	323.76	230.30	73.86	176.34
209.36	303.97	215.84	69.04	165.85	**74**	232.40	337.40	239.58	76.63	184.10
217.48	316.26	224.21	71.41	172.83	**75**	241.40	351.05	248.86	79.26	191.85
225.59	328.55	232.57	73.86	179.82	**76**	250.40	364.69	258.15	81.99	199.60
233.70	340.84	240.93	75.89	186.81	**77**	259.41	378.34	267.43	84.25	207.36
242.11	352.43	249.60	77.95	193.53	**78**	268.75	391.20	277.06	86.53	214.82
250.53	364.02	258.28	80.16	200.26	**79**	278.09	404.07	286.68	88.98	222.29
258.94	375.61	266.95	82.36	206.99	**80**	287.42	416.93	296.31	91.41	229.76
267.36	387.20	275.62	85.16	213.71	**81**	296.76	429.79	305.94	94.52	237.22
275.76	398.79	284.29	87.97	220.44	**82**	306.10	442.66	315.57	97.64	244.68
285.69	413.94	294.53	90.78	228.37	**83**	317.12	459.48	326.93	100.77	253.49
295.62	429.10	304.76	93.57	236.30	**84**	328.15	476.30	338.29	103.87	262.30
305.55	444.25	315.00	96.36	244.24	**85**	339.16	493.12	349.65	106.95	271.11
315.48	459.41	325.23	99.10	252.18	**86**	350.18	509.94	361.01	110.01	279.92
325.41	474.56	335.47	101.83	260.12	**87**	361.19	526.76	372.37	113.04	288.73
331.91	484.05	342.18	104.52	265.31	**88**	368.42	537.30	379.82	116.01	294.50
338.55	493.74	349.02	107.16	270.63	**89**	375.79	548.04	387.41	118.95	300.39
345.32	503.61	356.00	109.73	276.04	**90**	383.31	559.00	395.16	121.80	306.40
352.23	513.68	363.13	112.48	281.56	**91**	390.97	570.19	403.06	124.85	312.52
359.27	523.96	370.39	115.29	287.19	**92**	398.79	581.59	411.13	127.97	318.78
366.46	534.44	377.79	118.18	292.93	**93**	406.77	593.22	419.35	131.18	325.16
373.79	545.12	385.35	121.14	298.79	**94**	414.90	605.08	427.74	134.46	331.65
381.26	556.02	393.05	124.17	304.76	**95**	423.20	617.18	436.29	137.83	338.29
388.89	567.14	400.92	127.28	310.86	**96**	431.66	629.53	445.01	141.28	345.06
396.66	578.49	408.93	130.47	317.08	**97**	440.30	642.12	453.92	144.83	351.96
404.60	590.05	417.11	133.74	323.42	**98**	449.11	654.96	463.00	148.45	359.00
412.69	601.86	425.46	137.09	329.89	**99+**	458.08	668.07	472.25	152.17	366.17

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.
To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

Premium Information
The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. This annual premium change will occur on the first policy renewal date which coincides with or follows the policy anniversary date.

A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies using this form issued in the same state to persons of the same classification.

Risk Class Rating
If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I – 10% or Class II – 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

Household Premium Discount
You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

Read Your Policy Very Carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right to Return Policy
If you find that you are not satisfied with your policy, you may return it to 3300 Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

Policy Replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice
The policy may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,556	$0	$1,556 (Part A deductible)
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

Medicare first eligible before 2020 only

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,556	$1,556 (Part A deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
Medicare first eligible before 2020 only

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $233 of Medicare-approved amounts	$0	$233 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $233 of Medicare-approved amounts	$0	$233 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $233 of Medicare-approved amounts	$0	$233 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR
Medicare first eligible before 2020 only

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,556	$1,556 (Part A deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,556	$1,556 (Part A deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $233 of Medicare-approved amounts*	$0	$0	$233 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $233 of Medicare-approved amounts*	$0	$0	$233 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $233 of Medicare-approved amounts*	$0	$0	$233 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	$0

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,556	$1,556 (Part A deductible)	$0
61st through 90th day	All but $389 a day	$389 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

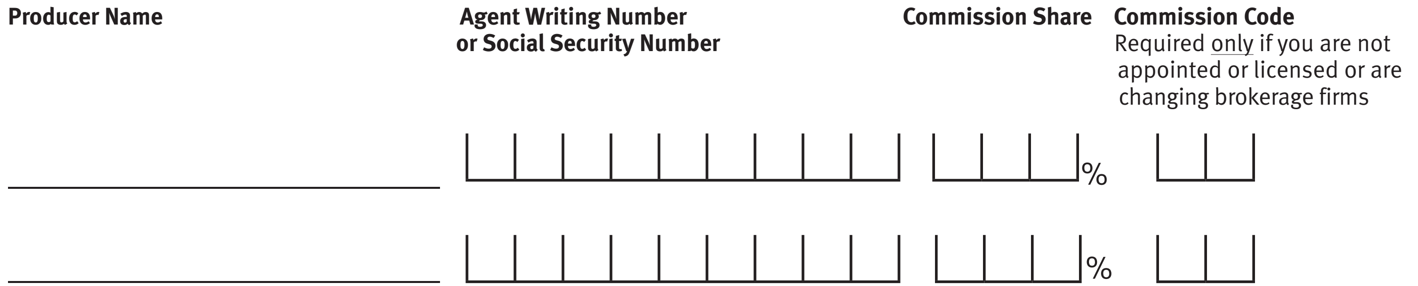
PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
DURABLE MEDICAL EQUIPMENT First $233 of Medicare-approved amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit

Producer Information – Please Complete



Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or are changing brokerage firms
		%	
		%	

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: ____________________

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – United World Life Ins. Co. Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Household Premium Discount Information
- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections F and G – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions
- If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) OR question 8 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section I: Agreement and Authorization
- Make sure applicant(s) sign and date the application

Section K: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Calculate Your Premium form**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices**

Note: An interviewer may call to verify/confirm the information provided on the application.

This form is required if splitting commissions.

Mutual of Omaha is excited to introduce our new comprehensive wellness program called Mutually Well. Please visit www.mutuallywell.com for more information and to enroll.

W143406_OR

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:
(Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.
Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

- *If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*
- *If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.*

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility (Can vary by situation, refer to Underwriting Guide):

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)
g. Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

M27788_0819

Underwritten by
United World Life Insurance Company
A Mutual of Omaha Company

3316 Farnam Street
Omaha, Nebraska 68175

Calculate Your Premium **PLEASE COMPLETE**

Medicare Supplement Insurance Plan

Applicant A ______

Applicant B _______

Before you begin: *Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.*

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	**Age** Write in your age at the time of signing the application. **ZIP Code** Indicate your ZIP Code used to determine your rate.	65 51502		
#2	**Premium** Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	$128.52		
#3	**Household Premium Discount** Please refer to the application for state specific household discount premium rules. **If the rules apply**, multiply the amount from Step #2 by .88. **If the rules do not apply**, enter the amount from Step #2.	$128.52 x .88 = $113.10 In this example, the person qualifies for the household premium discount.		
#4	**Rate Adjustment** If you're in your open enrollment or guaranteed issue period, skip to Step #5. Locate your height, then weight on the next page. • If your weight is in the Standard column, enter the amount from Step #3 • If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 1.20 if in Class II column	$113.10 x 1.20 = $135.70 Person's weight is in the Class II column.		
#5	**Payment Options** Your monthly payment is your last premium entered (Step #3 or #4). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	$135.70 monthly payment $407.10 quarterly payment $814.20 semiannual payment $1,628.40 annual payment		

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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	< 54	54 – 60	61 – 110	111 – 128	129 – 145	146 +
4' 3''	< 56	56 – 62	63 – 114	115 – 133	134 – 151	152 +
4' 4''	< 58	58 – 65	66 – 119	120 – 138	139 – 157	158 +
4' 5''	< 60	60 – 67	68 – 123	124 – 143	144 – 163	164 +
4' 6''	< 63	63 – 70	71 – 128	129 – 149	150 – 170	171 +
4' 7''	< 65	65 – 73	74 – 133	134 – 154	155 – 176	177 +
4' 8''	< 67	67 – 75	76 – 138	139 – 160	161 – 182	183 +
4' 9''	< 70	70 – 78	79 – 143	144 – 166	167 – 189	190 +
4' 10''	< 72	72 – 81	82 – 148	149 – 172	173 – 196	197 +
4' 11''	< 75	75 – 84	85 – 153	154 – 178	179 – 202	203 +
5' 0''	< 77	77 – 87	88 – 158	159 – 184	185 – 209	210 +
5' 1''	< 80	80 – 89	90 – 164	165 – 190	191 – 216	217 +
5' 2''	< 83	83 – 92	93 – 169	170 – 196	197 – 224	225 +
5' 3''	< 85	85 – 95	96 – 175	176 – 203	204 – 231	232 +
5' 4''	< 88	88 – 99	100 – 180	181 – 209	210 – 238	239 +
5' 5''	< 91	91 – 102	103 – 186	187 – 216	217 – 246	247 +
5' 6''	< 93	93 – 105	106 – 192	193 – 223	224 – 254	255 +
5' 7''	< 96	96 – 108	109 – 197	198 – 229	230 – 261	262 +
5' 8''	< 99	99 – 111	112 – 203	204 – 236	237 – 269	270 +
5' 9''	< 102	102 – 115	116 – 209	210 – 243	244 – 277	278 +
5' 10''	< 105	105 – 118	119 – 216	217 – 250	251 – 285	286 +
5' 11''	< 108	108 – 121	122 – 222	223 – 258	259 – 293	294 +
6' 0''	< 111	111 – 125	126 – 228	229 – 265	266 – 302	303 +
6' 1''	< 114	114 – 128	129 – 234	235 – 272	273 – 310	311 +
6' 2''	< 117	117 – 132	133 – 241	242 – 280	281 – 319	320 +
6' 3''	< 121	121 – 136	137 – 248	249 – 288	289 – 328	329 +
6' 4''	< 124	124 – 139	140 – 254	255 – 295	296 – 336	337 +
6' 5''	< 127	127 – 143	144 – 261	262 – 303	304 – 345	346 +
6' 6''	< 130	130 – 147	148 – 268	269 – 311	312 – 354	355 +
6' 7''	< 134	134 – 150	151 – 275	276 – 319	320 – 363	364 +
6' 8''	< 137	137 – 154	155 – 282	283 – 327	328 – 373	374 +
6' 9''	< 140	140 – 158	159 – 289	290 – 335	336 – 382	383 +
6' 10''	< 144	144 – 162	163 – 296	297 – 344	345 – 392	393 +
6' 11''	< 147	147 – 166	167 – 303	304 – 352	353 – 401	402 +
7' 0''	< 151	151 – 170	171 – 311	312 – 361	362 – 411	412 +
7' 1''	< 155	155 – 174	175 – 318	319 – 369	370 – 421	422 +
7' 2''	< 158	158 – 178	179 – 326	327 – 378	379 – 431	432 +
7' 3''	< 162	162 – 183	184 – 333	334 – 387	388 – 441	442 +
7' 4''	< 166	166 – 187	188 – 341	342 – 396	397 – 451	452 +

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