

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL OF OMAHA COMPANY

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Mutual of Omaha

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# CONTACTS

## Addresses for Mailing New Business and Delivery Receipts

When mailing or shipping your new business applications, be sure to use the preaddressed envelopes.

### Agency Mailing Information

Please forward all completed applications to your appropriate Division Office, who will forward them onto Mutual of Omaha's Blair Facility.

### Brokerage Mailing Information

#### Mailing Address

United of Omaha  
P.O. Box 3608  
Omaha, NE 68103

#### Overnight/Express Address

United of Omaha  
Records/Mailing Processing Center  
9330 State Highway 133  
Blair, NE 68008-6179

### FAX Number for New Business (Brokerage ONLY) - ACH Applications

1-402-351-1078

### Sales Professional Access (SPA) Links

**Agents:** [http://www.mutualofomaha.com/sales\\_professionals/index.html](http://www.mutualofomaha.com/sales_professionals/index.html)

**Brokers:** [www.mutualofomaha.com/broker](http://www.mutualofomaha.com/broker)

### Important Phone Numbers

Area	Phone Number
Underwriting	1-800-995-9324
Sales Support, Brokerage	1-800-693-6083
Sales Support, Agency	1-877-617-5589
Licensing, Brokerage/Agency	1-800-867-6873
Supplies, Brokerage	1-800-673-6493
Supplies, Agency	Contact Local Division Office
Compensation Support Center, Brokerage	1-800-475-4465
Compensation Support Center, Agency	1-800-775-2212
Customer Service	1-800-354-3289

# INTRODUCTION

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare supplement insurance policies. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any problems with an application.

# POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A & B in Michigan and Texas; in all other states, only Part A is required. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issue. If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence. Please refer to your introductory materials for required forms specific to your state.

## Open Enrollment

To be eligible for open enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period upon reaching age 65.

## Under Age 65

- **Texas:** Plan A is available. Coverage is guaranteed issue if applied for within six months of Part B enrollment.
- **New Hampshire:** All plans are available. Coverage is guaranteed issue if applied for within six months of Part B enrollment.

## Selective Issue

Applicants over the age of 65 and at least six months beyond enrollment in Medicare Part B will be selectively underwritten. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined. Elimination endorsements will not be used.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Applicants who fall outside the established guidelines for standard rating could receive a premium rate increase of 10%, 20% or be declined. In the state of Texas, premium rate-ups do not apply. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

## Application Dates

- Open Enrollment – Up to six months prior to the month the applicant turns age 65
- West Virginia applications may be taken up to 30 days prior to the month the applicant turns age 65
- Underwritten Cases – Up to 60 days

## Coverage Effective Dates

Coverage will be made effective as indicated below:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65
2. All Others – Application date or date of termination of other coverage, whichever is later

## Replacements

A "replacement" takes place when an applicant wishes to exchange an existing Medicare supplement policy from United World, one of our affiliate companies (internal), or any other company (external), for a newer or different Medicare supplement/Select policy. Internal replacements are processed the same as external, requiring a fully completed application.

A policyowner wanting to apply for a nontobacco plan must complete a new application and qualify for coverage.

Policyowners wishing to change their Risk Class rating because of weight loss must maintain that weight loss for at least 12 months. A new application is required and will be underwritten.

The policy to be replaced must be in force on the date of replacement. All replacements involving a Medicare supplement, Medicare Select or Medicare Advantage plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application.

The Medicare supplement policy cannot be issued in addition to any other Medicare supplement, Select or Medicare Advantage plan.

### Medicare Select to Medicare Supplement Conversion Privilege

Policyowners covered under a Medicare Select plan with United of Omaha may decide they no longer wish to participate in our hospital network. Coverage may be converted to one of our Medicare supplement plans not containing network restrictions. We will make available any Medicare supplement policy offered in their state that provides equal or lesser benefits. A new application must be completed; however, evidence of insurability will not be required if the Medicare Select policy has been in force for at least six months at the time of conversion.

### Telephone Interviews

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.

### Pharmaceutical Information

United of Omaha has implemented a process to support the collection of pharmaceutical information for underwritten Medicare supplement applications. In order to obtain the pharmaceutical information as requested, please be sure to include a completed “Authorization to Disclose Personal Information (HIPAA)” form with all underwritten applications. This form can be found in the Application Packet. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

### Policy Delivery Receipt

Delivery receipts are required on all policies issued in West Virginia.

Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to United of Omaha in the postage paid envelope which is also included in the policy package.

### Guarantee Issue Rules

The rules listed below can also be found in the Guide to Health Insurance.

Guarantee Issue Situation	Client has the right to buy. . .
Client is in the original Medicare Plan and has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. <b>Note:</b> In this situation, state laws may vary.	Medigap Plan A, B, C, F, K or L that is sold in client’s state by any insurance company.  If client has COBRA coverage, client can either buy a Medigap policy right away or wait until the COBRA coverage ends.
Client is in the original Medicare Plan and has a Medicare SELECT policy. Client moves out of the Medicare SELECT plan’s service area.  You can keep your Medigap policy or you may want to switch to another Medigap policy.	Medigap Plan A, B, C, F, K or L that is sold by any insurance company in client’s state or the state they are moving to.
Client’s Medigap insurance company goes bankrupt and the client loses coverage, or client’s Medigap policy coverage otherwise ends through no fault of client.	Medigap Plan A, B, C, F, K or L that is sold in client’s state by any insurance company.

# MEDICARE ADVANTAGE (MA)

## Medicare Advantage (MA) Annual Election Period

General Election Periods for Medicare Advantage (MA)	Timeframe	Allows for...
Annual Election Period (AEP)	Nov. 15 <sup>th</sup> – Dec. 31 <sup>st</sup> of every year	<ul style="list-style-type: none"> <li>• Enrollment selection for a MA plan</li> <li>• Disenroll from a current MA plan</li> <li>• Enrollment selection for Medicare Part D</li> </ul>
Open Enrollment Period (OEP)	Jan. 1 <sup>st</sup> – Mar. 31 <sup>st</sup> of every year	<ul style="list-style-type: none"> <li>• MA eligible individuals can make one MA OEP election</li> <li>• Disenroll from a MA-only plan</li> </ul>

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local SHIP office for direction.

## Medicare Advantage (MA) Proof of Disenrollment

If applying for Medicare supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare, the MA plan must notify the member of his/her Medicare supplement guarantee issues rights.

### Disenroll during AEP and OEP

Complete the MA section on the Medicare supplement application; and

1. Send **ONE** of the following with the application
  - a. A copy of the applicant's MA plan's disenrollment notice
  - b. A copy of the letter the applicant sent to his/her MA plan requesting disenrollment
  - c. A signed statement that the applicant has requested to be disenrolled from his/her MA plan.

### If an individual is disenrolling after March 31 (outside AEP/OEP):

1. Complete the MA section on the Medicare supplement application; and
2. Send a copy of the applicant's MA plan's disenrollment notice with the application.

For any questions regarding MA disenrollment eligibility, contact your State Health Insurance Assistance Program (SHIP) office or call 1-800-MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

## Guarantee Issue Rights

The rights listed below can also be found in the *Guide to Health Insurance*.

Guarantee Issue Situation	Client has the right to...
Client's MA plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the plan's service area.	buy a Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance carrier. Client must switch to Original Medicare Plan.
Client joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to Original Medicare.	buy any Medigap plan that is sold in your state by any insurance company.
Client dropped his/her Medigap policy to join an MA Plan for the first time, have been in the plan less than a year and want to switch back.	obtain client's Medigap policy back if that carrier still sells it. If his/her former Medigap policy is not available, the client can buy a Medigap Plan A, B, C, F, K or L that is sold in his/her state by any insurance company.
Client leaves an MA plan because the company has not followed the rules, or misled them.	buy Medigap plan A, B, C, F, K or L that is sold in the client's state by any insurance company.

If you believe another situation exists, please contact the client's local SHIP office.

# PREMIUM

## Calculating Premium

### Utilize Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if non-tobacco or tobacco
- Find Age/Gender - Verify that **the age and date of birth** are the exact age as of the application date
- This will be your **base** monthly premium

### Utilizing form UC6582, Calculate Your Premium Form

- Enter the **base** premium on line # 1 and proceed with the instructions that follow

## Household Discount

### How to determine eligibility for household discount

- Refer to Section 5 on the application
- If either 5 (a) or 5 (b) are answered “Yes,” the individual qualifies

### The household discount is available to:

- Individuals who reside together for at least one year (or are married), apply together for and are both issued United of Omaha policies
- Individuals who reside for at least one year with (or are married to) another Med supp policyholder who currently owns a Mutual of Omaha, United World, or United of Omaha Med supp policy. The discount only applies to the United of Omaha premium

## Class Rating *(not applicable in all states)*

### How to determine class rating

- Follow instructions on the Calculate Your Premium Form
- Complete the form and return with the application

Height and weight charts are included on pages 9 and 10 of the Guide for your reference.

## Height and Weight Chart for States WITH Class Rating

Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

### 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 +

## Height and Weight Chart for States WITHOUT Class Rating

Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

### Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

	<b>Decline</b>	<b>Standard</b>	<b>Decline</b>
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

## Completing the Premium On the Application

### Initial Premium

- The amount in line #4 will be the amount you enter on the Premium Collected box located on the application
- Circle the appropriate mode for the **initial** payment

### Renewal Premium

- Determine how the client wants to be billed going forward (**renewal**) and select the appropriate mode on the Renewal Mode section on the application
- Indicate, based on the mode selected, the renewal premium. **Monthly direct is not allowed**

**NOTE:** If utilizing electronic funds as a method of payment, please complete the Authorization To Withdraw Funds Form.

### **Collection of Premium**

At least one month's premium must be submitted with the application. If a mode other than monthly is selected, then the full modal premium must be submitted with the application.

**NOTE:** The Company does not accept Third Party Checks, including checks from any Foundations as premium for Medicare Supplement/Select or post dated checks.

### **Business Checks**

If premium is paid by business check, complete the information located on the Producer Information form.

### **Conditional Receipt**

The Conditional Receipt must be completed and provided to applicant if premium is collected.

**NOTE:** Do not mail a copy of the receipt with the application.

### **Shortages**

The company will communicate with the producer by telephone, e-mail or FAX in the event of a premium shortage. The application will be held in pending until the balance of the premium is received. Producers may communicate with Underwriting by calling 1-800-995-9324 or by FAX at 1-402-351-2552.

### **Refunds**

The company will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

### **Our General Administrative Rule – 12 Month Rate**

Our current administrative practice is not to adjust rates for 12 months from the application date.

# APPLICATION

Properly completed applications should be finalized within 5-7 days of receipt at United of Omaha. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

## Application Sections

The Medicare supplement application consists of seven sections that must be completed. Please be sure to review your applications for the following information before submitting.

### Plan Information Section

- Entire Section must be completed
- This section should indicate the plan or policy form selected, effective date, premium paid, and the premium payment mode selected — **both initial and renewal**

### Section 1 — Applicant Information

- Please complete the client's residence address in full. If premium notices are to be mailed to an address other than the applicant's residence address, please complete the mailing address in full
- Age and Date of Birth are the **exact age** as of the **application date**
- Medicare Card number, also referred to as the Health Insurance Claim (HIC) number, is vital for electronic claims payment
- Height/Weight — This is required on underwritten cases and is required for premium calculation

### Section 2 — Miscellaneous Questions

- Verify the applicant answered "Yes" to receiving the *Guide to Health Insurance* and Outline of Coverage. It is required to leave these two documents with the client at the time the application is completed
- Please indicate if the applicant is covered under Parts A and B of Medicare

### Section 3 — Insurance Policies /Certificates

- If the applicant is applying during a Guarantee Issue period, be sure to include proof of eligibility
- If the applicant is replacing another Medicare supplement policy, complete question #2 and include the replacement notice
- If the applicant is leaving a Medicare Advantage plan, complete question #3 and include the replacement notice
- If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer plan, or other non-Medicare supplement coverage, complete question #4
- Verify if the applicant is covered through his/her state Medicaid program

### Section 4 — Health Questions

- If the applicant is applying during an open enrollment or a guarantee issue period, **do not** answer the health questions or prescription information
- If applicant is not considered to be in open enrollment or a guarantee issue situation, all health questions must be answered, including the question regarding prescription medications

**NOTE:** In order to be considered eligible for coverage, all health questions must be answered "No." For questions on how to answer a particular health question, see the **Health Questions** section of this Guide for clarification.

### Section 5 — Household Discount

- Answer both questions 5(a) and 5(b)
- If either 5(a) or 5(b) are answered "Yes," the individual qualifies for this discount
- This information is necessary for premium calculation

## Section 6 — Signatures

- Signatures and dates: required by both applicant(s) and producer. The producer must be appointed in the state where the application is signed

**NOTE:** Applicant's signature must match name of applicant on the application. In rare cases where applicant cannot sign his/her name, a mark ("X") is acceptable. *For their own protection, producers are advised against acting as sole witness.*

- If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative

# HEALTH QUESTIONS

Unless an application is completed during open enrollment or a guarantee issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare supplement coverage if any of the health questions are answered “Yes.” For a list of uninsurable conditions and the related medications associated with these conditions, please refer to pages 13 and 14.

There may, however, be situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in health questions 8, 9 and 10.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If this situation exists and you would like consideration to be given to the application, answer the appropriate question “Yes,” and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications.

If you have had questions about the interpretation of health questions 6 and 7 on the application, please see the information below.

People with diabetes mellitus that require, or has ever required, more than 50 units of insulin daily, or people with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions listed in question #6 on the application, are not eligible for coverage. For purposes of this question, hypertension (high blood pressure) is considered a heart condition. Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes. A case is considered to be well controlled if the person is taking less than 50 units of insulin daily or no more than two oral medications for diabetes and no more than two medications for hypertension. A combination of less than 50 units of insulin a day and one oral medication would be the same as two oral medications if the diabetes were well controlled. In general, to verify stability, there should be no changes in the dosages or medications for at least two years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower.

## Uninsurable Health Conditions

Applications should not be submitted if applicant has the following conditions:

Emphysema	Lateral Sclerosis (ALS)
Chronic Obstructive Pulmonary Disease (COPD)	Osteoporosis with fracture
Other chronic pulmonary disorders to include:	Spinal Stenosis
Chronic bronchitis	Cirrhosis
Chronic obstructive lung disease (COLD)	Kidney disease requiring dialysis
Chronic asthma	Alzheimer's Disease
Chronic interstitial lung disease	Senile Dementia
Chronic pulmonary fibrosis	Other cognitive disorders to include:
Cystic fibrosis	Mild cognitive impairment (MCI)
Sarcoidosis	Delirium
Bronchiectasis	Organic brain disorder
Scleroderma	AIDS
Parkinson's Disease	ARC
Lupus – Systemic	Diabetes > 50 units insulin daily
Myasthenia Gravis	Organ transplant
Multiple Sclerosis	

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, treatment or therapy
- If applicant's height/weight is in the decline column on the chart

## Partial List of Medications Associated with Uninsurable Health Conditions

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

3TC	AIDS	Megace	Cancer
Alkeran	Cancer	Megestrol	Cancer
Amantadine	Parkinson's Disease	Mellaril	Psychosis
Apokyn	Parkinson's Disease	Melphalan	Cancer
Aricept	Dementia	Memantine	Alzheimer's Disease
Artane	Dementia	Methotrexate (>25mg/wk)	Rheumatoid Arthritis
Avonex	Multiple Sclerosis	Metrifonate	Dementia
Azilect	Parkinson's Disease	Mirapex	Parkinson's Disease
AZT	AIDS	Myleran	Cancer
Baclofen	Multiple Sclerosis	Namenda	Alzheimer's Disease
Betaseron	Multiple Sclerosis	Narcotics	Chronic Pain
Cerefolin	Dementia	Navane	Psychosis
Carbidopa	Parkinson's Disease	Nelfinavir	AIDS
Cogentin	Parkinson's Disease	Neoral	Immunosuppression, Severe Arthritis
Cognex	Dementia	Neupro	Parkinson's Disease
Comtan	Parkinson's Disease	Paraplatin	Cancer
Copaxone	Multiple Sclerosis	Parlodel	Parkinson's Disease
Cytoxan	Cancer, Severe Arthritis Immunosuppression	Permax	Parkinson's Disease
D4T	AIDS	Prednisone (>10 mg/day)	Rheumatoid Arthritis
DDC	AIDS	Procrit	Kidney Failure, AIDS
DDI	AIDS	Prolixin	Psychosis
DES	Cancer	Razadyne	Dementia
Eldepryl	Parkinson's Disease	Remicade	Rheumatoid Arthritis
Embrel	Rheumatoid Arthritis	Reminyl	Dementia
Epogen	Kidney Failure, AIDS	Requip	Parkinson's Disease
Ergoloid	Dementia	Retrovir	AIDS
Exelon	Dementia	Rebif	Multiple Sclerosis
Galantamine	Dementia	Riluzole	ALS
Gold	Rheumatoid Arthritis	Risperdal	Psychosis
Haldol	Psychosis	Ritonavir	AIDS
Herceptin	Cancer	Sandimmune	Immunosuppression, Severe Arthritis
Hydrea	Cancer	Sinemet	Parkinson's Disease
Hydergine	Dementia	Stalevo	Parkinson's Disease
Imuran	Immunosuppression, Severe Arthritis	Stelazine	Psychosis
Insulin (>50 units/day)	Diabetes	Sustiva	AIDS
Interferon	AIDS, Cancer, Hepatitis	Symmetrel	Parkinson's Disease
Indinavir	AIDS	Tacrine	Dementia
Invirase	AIDS	Tasmar	Parkinson's Disease
Kemadrin	Parkinson's Disease	Teslac	Cancer
Lasix (>60 mg/day)	Heart Disease	Thiotepa	Cancer
L-Dopa	Parkinson's Disease	Thorazine	Psychosis
Leukeran	Cancer, Immunosuppression, Severe Arthritis	Tysabri	Multiple Sclerosis
Levodopa	Parkinson's Disease	VePesid	Cancer
Lioresal	Multiple Sclerosis	Vincristine	Cancer
Lomustine	Cancer	Viramune	AIDS
		Zanosar	Cancer
		Zelapar	Parkinson's Disease
		Zoladex	Cancer

# REQUIRED FORMS

## **Application**

Only current Medicare supplement applications may be used in applying for coverage. A copy of the completed application will be made by United of Omaha and attached to the policy to make it part of the contract.

The Producer or designated office staff is responsible for submitting completed applications to United of Omaha.

## **Producer Information Page (Brokerage ONLY)**

Producers must include their name and Social Security number. A maximum of two producers is allowed and they should indicate the commission percentage shares, which must total 100%.

## **Authorization to Withdraw Funds Form**

If premiums are paid by automatic bank draft, complete this form.

## **Conditional Receipt**

Must be completed and provided to applicant as receipt for premium collected.

## **HIPAA Authorization Form**

Required with all underwritten applications.

## **Replacement Form**

The replacement form must be signed and submitted with the application when replacing any Medicare supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

## **Select Disclosure Agreement**

The Select Disclosure Agreement form must be signed and submitted with the application when a Select plan is chosen (Select plan not available in all states).