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

Mutual of Omaha appreciates the opportunity to provide you with continued disability insurance protection. So that we can effectively process your request for insurance under our disability 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 Group Disability Continuation Request Form is a request for insurance under Mutual of Omaha's Disability Continuation Plan(s). Insurance under a continuation plan is available to employees when insurance under a Mutual of Omaha group disability insurance plan offered by an employer/group ends for certain reasons.

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 employer/ 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: Group and Employee Eligibility 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. Information regarding the employee's eligibility, and identification of the coverage(s) eligible for continuation, must also be provided.

Short-Term Disability (STD) and/or Long-Term Disability (LTD) is only eligible for continuation if the group policy for the specific insurance contained a continuation provision rider, either Portability or Conversion.

Section 2: Applicant Information

Please provide all required applicant information. The applicant must be age 69 or less to be eligible for insurance. Once insured under these plans, coverage does not terminate based on age only.

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: Continuation Insurance Election

Indicate the type of disability insurance you wish to continue, either STD only (20, 30, or 60% option), LTD only, or both. Remember, insurance is only eligible for continuation if the group policy for the specific insurance contained a continuation provision rider, either Portability or Conversion.

Section 4: Monthly Rates

These are the monthly rates for insurance under the continuation plans. The rates are age banded, which means that the premium for insurance is assessed according to age – as you age and advance to the next age band, the premium for your insurance will increase accordingly. The initial premium payment is based on your current age.

The rates presented in Section 4 are used in Section 5 to determine the premium for your insurance under the continuation plans.

Section 5: Benefit Amount and Initial Premium Payment Calculation

Complete this section for the insurance you are requesting continuation of, either STD, LTD or both. Work through the steps to determine your benefit amount, as well as your monthly premium for the insurance.

Determining the Maximum Benefit (Steps "D" or "L") – The STD disability continuation plans will replace up to 20, 30, or 60 percent and LTD will replace up to 60 percent of your income in effect at the time your insurance under the employer's group plan ended. Insurance is available on a guarantee issue basis (automatically available without provision of health information) for:

- Up to $700 of weekly benefit for STD (the STD Guarantee Issue Amount)
- Up to $3,000 of monthly benefit for LTD (the LTD Guarantee Issue Amount)

If you are only requesting insurance up to the Guarantee Issue Amount, then:

- $700 is the Maximum Weekly Benefit you enter in Step D for STD
- $3,000 is the Maximum Monthly Benefit you enter in Step L for LTD

If your annual income is greater than $60,000, you have the opportunity to apply for insurance in excess of the Guarantee Issue Amount. You apply for this additional insurance by completing the Group Disability Evidence of Insurability Form and submitting it with this request form.

SECTION 5: BENEFIT AMOUNT AND INITIAL PREMIUM PAYMENT CALCULATION (CONTINUED)

If you will be applying for insurance in excess of the Guarantee Issue Amount and will be submitting the evidence of insurability form, then:

- $1,400 is the Maximum Weekly Benefit you enter in Step D for STD
- $6,000 is the Maximum Monthly Benefit you enter in Step L for LTD

Determining the Billing Frequency (Step "R") – To pay premium every 3 months (Quarterly), insert a 3. To pay premium twice a year (Semiannually), insert a 6. To pay premium once a year (Annually), insert a 12.

If you are also eligible for and electing continuation of group term life insurance under the portability provision, the billing frequency must be the same on both requests.

SECTION 6: ELIGIBILITY CONDITIONS

To be eligible for insurance, you must be able to satisfy all of the conditions listed in Section 6.

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 these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form, the evidence of insurability form (if applicable) and your initial premium payment to Mutual of Omaha as soon as possible after your insurance ends under the group plan.

Remember, to be considered for insurance under the disability continuation plan(s), your request must be received within 31 days of the date insurance under the group plan ended.

Benefits Summary

	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Benefits Begin (Elimination Period)	If you become disabled, there is an elimination period before benefits are payable.	
	STD benefits begin 30 days after the onset of your disabling injury or illness.	LTD benefits begin 180 days after the onset of your disabling injury or illness.
Benefit Amount	Options of 20% or 30% that do not integrate with other income sources, or the 60% option that will offset with other income sources, not to exceed the plan's maximum weekly benefit amount.	60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount (less other income sources).
Maximum Benefit Amount	▪ $700 per week guarantee issue ▪ $1,400 per week with approved evidence of insurability	▪ $3,000 per month guarantee issue ▪ $6,000 per month with approved evidence of insurability
Maximum Benefit Period	Benefits are available for up to 26 weeks.	If you become disabled prior to age 60, benefits are payable to age 65. At age 60 (and older), the benefit period will be based on a reduced duration schedule.
Survivor Benefit	If you pass away while receiving benefits, your benefits will be provided to your eligible survivors for a period of time after your death.	
Alcohol and Drug Abuse Benefits	NA	For disabilities related to drug and alcohol abuse, benefits are available for up to 24 months.
Mental Disorder Benefits	NA	For disabilities related to mental disorders, benefits are available for up to 24 months.
Partial	NA	NA

Group Disability Continuation Request Form

Premium Services
Underwritten by: Mutual of Omaha Insurance Company

Please refer to "A Guide for Successfully Completing the Group Disability 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 and Employee Eligibility Information (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name*	**Group ID Number***
	G000 __ __ __ __

Coverage(s) Eligible for Continuation*†	**Annual Salary***	**Last Monthly Premium Amount*‡**
☐ Short-Term Disability (STD) ☐ Long-Term Disability (LTD)	$	$

Date of Hire (MM/DD/YYYY)*	**Initial Coverage Effective Date** (MM/DD/YYYY)*
	STD (if applicable) _____ LTD (if applicable) _____

Last Day Worked (MM/DD/YYYY)*	**Date of Status Change/Termination/Layoff** (MM/DD/YYYY)*

†*A coverage is only eligible for continuation if the group policy for the specific coverage contained a continuation provision rider (either Portability or Conversion).*
‡*Provide the last monthly premium amount remitted to Mutual of Omaha for the employee's coverage (available on the employer's last billing statement, if list-billed).*

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***
†*The applicant must be age 69 or less to be eligible for insurance.*		☐ Female ☐ Male

Consent to Email Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via email.

Reason for Request*

Please indicate why you are requesting continued disability insurance:
☐ Status Change/Reduction in Hours ☐ Employment Ended/Terminated ☐ Involuntary Layoff

Section 3: Continuation Insurance Election

Type of Insurance Requested†

☐ STD 20% ☐ STD 30% ☐ STD 60% ☐ LTD Only

†*Insurance is only eligible for continuation if the group policy for that specific insurance contained a continuation provision rider (either Portability or Conversion).*

Section 4: Monthly Rates

	Age	**0 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 69**	**70+**
STD Rates Per $10 of Weekly Benefit	20%	$1.251	$1.498	$1.817	$2.080	$2.665	$3.405	$4.238
	30%	$1.082	$1.281	$1.567	$1.787	$2.300	$2.954	$3.647
	60%	$0.946	$1.124	$1.362	$1.560	$1.982	$2.548	$3.185
LTD Rates Per $100 of Monthly Benefit		$1.680	$2.413	$3.317	$4.273	$4.643	$5.113	$5.113

Section 5: Benefit Amount and Initial Premium Payment Calculation

STD (Complete if applicable)		**LTD** (Complete if applicable)	
A. Enter your annual salary.	$	I. Enter your annual salary.	$
B. Multiply "A" times 20%, 30%, or 60% (the benefit percentage)	$	J. Multiply "I" times 60% (the benefit percentage)	$
C. Divide "B" by 52.	$	K. Divide "J" by 12.	$
D. Enter the Maximum Weekly Benefit.	$	L. Enter the Maximum Monthly Benefit.	$
E. Enter the lesser of "C" or "D." This is your STD Weekly Benefit Amount.	$	M. Enter the lesser of "K" or "L." This is your LTD Monthly Benefit Amount.	$
F. Divide "E" by 10.	$	N. Divide "M" by 100.	$
G. Enter the STD rate for your age from Section 4.	$	O. Enter the LTD rate for your age from Section 4.	$
H. Multiply "F" times "G."	$	P. Multiply "N" times "O."	$
		Q. Add "H" and "P" together, as applicable.	$
		R. Enter the billing frequency – 3 for Quarterly, 6 for Semiannual or 12 for Annual.	
		S. Multiply "Q" times "R." This is your **Initial Premium Payment**.	$

Section 6: Eligibility Conditions

To be eligible for disability continuation insurance, you satisfy all of the following conditions:

- You must be age 69 or less;
- You must not be disabled;
- You must not be retired;
- You must not be on a leave of absence from the employer (named in Section 1);
- You must not be unable to work for the employer (named in Section 1) due to a labor strike;
- You cannot be covered under any similar individual or group disability insurance plan or policy; and
- You must have been insured under the group disability plan offered by the employer (named in Section 1), and the plan it replaced (if applicable), for at least six consecutive months immediately prior to the date your eligibility for insurance under the group plan ended for STD.
- You must have been insured under the group disability plan offered by the employer (named in Section 1), and the plan it replaced (if applicable), for at least twelve consecutive months immediately prior to the date your eligibility for insurance under the group plan ended for LTD.

Section 7: Acknowledgement and Signature

I understand that I may request insurance under the continuation plan(s) subject to the following:

- I understand that the insurance available through disability continuation is subject to the rules of the policy governing each continuation plan (STD and/or LTD).
- I understand that I must satisfy the plan's requirements to be eligible for benefits, including the eligibility conditions outlined in Section 6 above, and that payment of premium does not ensure my 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 each continuation plan (STD or LTD).
- This request for insurance must be received by Mutual of Omaha within 31 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha. I understand that any insurance applied for in excess of the Guarantee Issue Amount is not effective until my application is approved by Mutual of Omaha.
- Premium amounts may increase as I 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 8: Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased 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) If you are requesting a benefit amount in excess of the Guarantee Issue Amount ($700 of weekly benefit for STD or $3,000 of monthly benefit for LTD), a completed and signed Group Disability Evidence of Insurability Form must be included with your submission for the extra insurance to be considered.

3) 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.

4) Submit this form, the evidence of insurability application (if applicable) 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.

☐ Check this box if you would like to be contacted by your local Mutual of Omaha insurance agent to discuss your insurance and financial planning needs.

Section 9: Required Fraud Warnings – Please Read (State specific warnings apply to the residents of each specific state.)

- **Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and 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/Kentucky/Louisiana/Maine/New Mexico/ 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.
- **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.
- **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.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil 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.
- **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 commits a fraudulent insurance act, which may be 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.
- **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.
- **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.