Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175

APPLICATION FOR ACCIDENTAL DEATH INSURANCE

FLORIDA

MAP555_FL_1212

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

✍ *CHECKLIST FOR SUBMITTING A COMPLETED APPLICATION*

Please mail application and appropriate forms to:

For regular mail submission:
Mutual of Omaha Insurance Company
P.O. Box 2351, Omaha, NE 68103-2351

For overnight submission:
Mutual of Omaha Insurance Company
9330 State HWY 133, Blair, NE 68008

For Fax submission:
Fax to 1-402-997-1800 and verify that the correct fax number is dialed to protect the privacy of the information contained in the application/forms. Use the maximum resolution to ensure the readability of the application.

☐ **Application**

1. Answer all questions completely and legibly.
2. If citizenship question is answered "No," complete Foreign National and Foreign Travel Questionnaire.
3. Leave all applicable forms with the Proposed Insured.
4. Sign and date in all places indicated.

☐ **Complete Premium Collection Section**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

☐ **Any Additional Information or Comments**

Include any supplemental information about your client.

_____

_____

_____

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_____

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

Mutual of Omaha Insurance Company

Application for Accidental Death Insurance

Home Office Use Only

Mutual of Omaha

SECTION A PRIMARY INSURED INFORMATION

Primary Insured's Legal Name _____

Legal Residence _____
Street City State Zip

Social Security Number _____-_____-_____ Gender ☐ Male ☐ Female Date of Birth _____/_____/_____

Age _____ Telephone Number ( ) _____- _____ E-mail _____

Are all Proposed Insureds citizens of the United States? ☐ Yes ☐ No

If "No," do all Proposed Insureds have a Permanent Resident Card (Form I-551) Number(s)? ☐ Yes ☐ No

If "Yes," Card Numbers(s) _____ Date of Arrival in U.S. _____

SECTION B INSURANCE APPLIED FOR

Accidental Death Insurance **Benefit Amount $**_____.

Benefits Include: 100% increase for Common Carrier Accidents
25% increase for Motor Vehicle/Auto Pedestrian Accidents

Type of Plan: (Select only one)

☐ Individual

☐ Family (Primary Insured plus one of the following:)

☐ Spouse only ☐ Spouse and children ☐ Children only

Rider:

☐ Return of Premium (ROP) Rider

Modal Premium $ _____. Amount Collected $ _____.

First Premium Payment: ☐ Bank Service Plan (BSP) ☐ Check

Subsequent Premium Payments: ☐ BSP ☐ Direct Bill

Payment Mode: ☐ Monthly BSP ☐ Quarterly ☐ Semiannual ☐ Annual

(Monthly Direct Bill not available)

SECTION C FAMILY COVERAGE INFORMATION

Additional Person(s) to be Insured	Full Name	Age	Date of Birth Month	Day	Year	Gender M	F
Spouse							
Child							
Child							
Child							

IMPORTANT: Please fill in the information requested above for each additional person to be insured. If you need more space to list your dependents, list them on a separate sheet of paper.

SECTION D BENEFICIARY INFORMATION

Primary Beneficiary Name: _____

Relationship: _____

Date of Birth: _____/_____/_____

Contingent Beneficiary Name: _____

Relationship: _____

Date of Birth: _____/_____/_____

Note: If no beneficiary is named, benefits will be paid to the Primary Insured's estate.

SECTION E REPLACEMENT INFORMATION

1. Is the coverage applied for replacing any existing coverage for any Proposed Insured? ..... Yes ☐ No ☐
2. Will the coverage being applied for be added to any existing coverage for any Proposed Insured? ..... Yes ☐ No ☐

If "Yes" to questions 1 or 2, please give details _____

_____

SECTION F AGREEMENT

The undersigned, understands and agrees that: (a) all statements and answers in this application are true and complete to the best of my knowledge and belief; (b) no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha Insurance Company during my lifetime; and (c) no producer or representative can waive or change any receipt or policy provision or agree to issue a policy.

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

I have (a) read and understand the Agreement and Fraud Warning Sections; (b) read and approved the answers as recorded on this application; and (c) received the appropriate Outline/Summary of Coverage.

Signed at: _____
City State

_____ _____ _____
Signature of Primary Insured | Printed Name of Primary Insured | Date

_____ _____ _____
Signature of Payor as shown on bank account (if Billing Mode is BSP and Payor is other than Proposed Insured) | Printed Name of Payor | Date

Agent Section:

I/We certify that during an interview with the Proposed Insured(s), I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ..... ☐ Yes ☐ No

(If "No," please explain.)_____

I conducted said interview in person ☐ Yes ☐ No

(If "No," please explain.)_____

_____ _____ _____ _____
Signature of Agent | Agent's Printed Name | Florida License # | Date

_____ _____
Office Name | Office Address

_____ _____ _____ _____
Signature of Agent | Agent's Printed Name | Florida License # | Date

_____ _____
Office Name | Office Address

Contact Name _____

Agent/Producer Statement

1 Do you have any reason to believe the policy applied for has replaced or will replace any existing insurance? (If "Yes," fulfill all state requirements.) ..... ☐ Yes ☐ No

2 Did you give the Notice of Information Practices to the Proposed Insured? ..... ☐ Yes ☐ No

Date _____ _____ _____
Mo. Day Yr. Agent/Producer's Signature Agent/Producer's Signature

Agent/Producer Information:

Agent/Producer Name _____ Agent/Producer Social Security Number _____

Comm. % Share _____ Agent/Producer Phone Number (_____) _____
Area Code

Agent/Producer E-mail Address _____

Agent/Producer's Stamp _____ Agent/Producer's License/ID Number _____

Agent/Producer Name _____ Agent/Producer Social Security Number _____

Comm. % Share _____ Agent/Producer Phone Number (_____) _____
Area Code

Agent/Producer E-mail Address _____

Agent/Producer's Stamp _____ Agent/Producer's License/ID Number _____

Mutual of Omaha Insurance Company

Mutual of Omaha Plaza, Omaha, NE 68175, 800-775-6000

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

Complete this form only when authorizing a bank account withdrawal for premium payment.

Payment Information

1. **Initial Premium Payment**

☐ Automated Bank Account Withdrawal ☐ Check Amount Quoted $_____

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON RECEIPT OF YOUR APPLICATION, BUT NO LATER THAN AT POLICY ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured/Insured will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**

☐ Automated Bank Account Withdrawal (Monthly)

Specify the date premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

Ongoing premiums are due and will be automatically withdrawn from the account below on the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

☐ Direct Bill (select one) ☐ Annual ☐ Semiannual ☐ Quarterly

Payor Information

Name of payor as shown on bank account: _____ Social Security No. _____

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

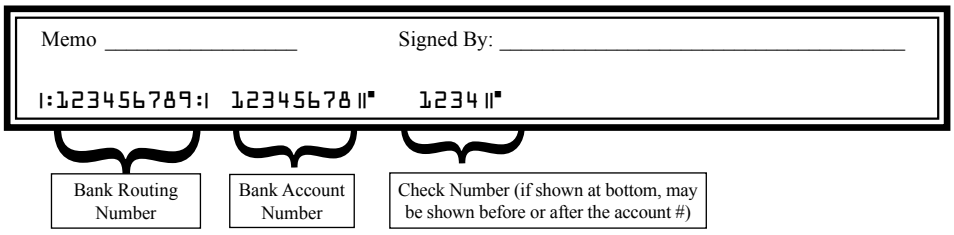
☐ Employer
☐ Business owned by Proposed Insured/Insured or Spouse
☐ Power of Attorney or legal guardian
☐ Living Trust
☐ Other _____

Account Information

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)



Authorization

I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date _____ X _____

Mo./Day/Yr. Authorized Signature as Shown on Account

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s).

Mutual of Omaha Insurance Company
Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

M26977

Remove Notice and Give to Proposed Insured

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

Accident-Only Insurance Coverage – Outline of Coverage

The Policy Provides Limited Benefits
Benefits Provided Are Supplemental And Are Not Intended To Cover All Medical Expenses

For Policy Form 50AD

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Accident-Only Coverage

Policies of this category are designed to provide coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

Accidental Death Benefit

If, while insured under this policy, an *insured person* sustains an *injury* which results in death within 365 days following the date of the *injury*, we will pay the Accidental Death Benefit shown on the policy schedule.

Common Carrier Accidental Death Benefit

Your policy may contain a common carrier accidental death benefit. If, while insured under this policy, an *insured person* sustains an *injury* while riding as a fare-paying passenger on a *common carrier* which results in death within 365 days following the date of the *injury*, we will pay a common carrier accidental death benefit. The common carrier accidental death benefit is shown on the policy schedule. This benefit is payable in addition to the accidental death benefit.

Auto/Pedestrian Accidental Death Benefit

Your policy may contain an auto/pedestrian accidental death benefit. If, while insured under this policy, an *insured person* sustains an *injury*:

(a) while driving or riding in any *private automobile*; or

(b) when struck by any motor vehicle ordinarily operated on public streets and highways

and such *injury* results in death within 365 days following the date of *injury*, we will pay an auto/pedestrian accidental death benefit. The auto/pedestrian accidental death benefit is shown on the policy schedule. This benefit is payable in addition to the accidental death benefit.

Exclusions

Your policy pays benefits only for loss resulting from *injuries*. We will not pay benefits for:

(a) death that occurs while this policy is not in force;

(b) death resulting directly or indirectly from disease or bodily infirmity;

(c) death resulting from an act of declared or undeclared war;

(d) death that occurs while serving in the armed forces;

(e) death caused by intentionally self-inflicted *injury*, while sane or insane;

(f) death caused by an *insured person's* suicide or attempted suicide, while sane or insane;

(g) death resulting from an *insured person's* commission or attempted commission of a felony;

(h) death resulting from an *insured person's* being intoxicated (as determined and defined by the laws of the jurisdiction in which the loss or cause of loss occurred; for the purposes of this exclusion, the laws governing the operation of motor vehicles while intoxicated will apply);

(i) death resulting from an *insured person's* being under the influence of any controlled substance (except for narcotics given on the advice of a physician);

(j) death resulting from a moving vehicle accident occurring while an *insured person* is engaged in a contest of speed, organized or not; or

(k) death resulting from flying in an aircraft unless sustained as a passenger (not as a pilot, operator or a member of the crew).

Guaranteed Renewable To Age 80

Your policy is guaranteed renewable until you reach *age 80*. This means you have the right to continue your policy until you reach *age 80*. Unless there has been a *material misrepresentation*, we cannot cancel your policy during that time as long as you pay the required premium before the end of each grace period.

Premiums Can Change

We may change the premium for your policy. However, we cannot make any premium change unless we make the same change to all policies of this form issued to persons of the same *class*. We will give you 45 days advance written notice before any premium change. Your premium will not increase during the first five years following the *policy date*.