



Мутуал Омаха

MUTUAL OF OMAHA INSURANCE COMPANY
HOME OFFICE: OMAHA, NEBRASKA

Application to Mutual of Omaha Insurance Company for Reinstatement of Policy Number _____

This space for name and address of Insured

1. Name _____ Height _____ Weight _____
Legal resident address _____ Occupation _____
Home phone number _____ Duties _____
Name of firm _____

Gross annual earned income from your occupation (after business expenses) \$ _____
Are you currently engaged in your occupation on a full-time basis? () Yes () No

- 2. Are you, your spouse or any named dependent:
(a) Pregnant? () Yes () No
(b) In good health and free from the effects of any injury, disability or deformity? () Yes () No
3. During the past TEN years, have you or any person proposed for insurance received medical care, medication or any advice or treatment for: (If "Yes," circle condition and give details in 6 below.)
(a) High blood pressure, chest pain, stroke or heart attack? () Yes () No
(b) Rheumatic fever, vascular surgery, cardiac pacemaker or any other form of heart or artery disease? () Yes () No
4. Within the past FIVE years, have you or any person proposed for insurance received any medical care, medication, advice or treatment for: (If "Yes," circle condition and give details in 6 below.)
(a) Any cancer of malignant growth or any lung disease or disorder? () Yes () No
(b) Cataracts or hernia? () Yes () No
(c) Diabetes? (If "Yes," state in 6 below whether controlled by insulin, oral medication or other means.) () Yes () No
(d) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Condition (ARC)? () Yes () No
(e) Any sickness or injury causing loss of or loss of use of any limb, sight or hearing? () Yes () No
(f) Other than those conditions named above, have you received or are you currently receiving medical treatment? () Yes () No
5. Other than above, during the last five years, have you or any person proposed for reinstatement: (Circle conditions answered "Yes" and give details in 6 below.)
(a) Been examined by a medical practitioner or received medical care for any mental or physical disorder or bodily injury not mentioned above? () Yes () No
(b) Taken any medication? () Yes () No
(c) Had a physical exam? () Yes () No

Table with 7 columns: Name, Diagnosis of Injury or Disease, Date (Month And Year), Duration of Hospital Confinement, Was Surgery Done?, Degree of Recovery, Name and Address of Hospital and/or Doctor

7. Have you or any named dependent been confined in a hospital within the past three years? () Yes () No
If "Yes," give full details _____

Table with 7 columns: Name, Diagnosis of Injury or Disease, Date (Month and Year), Duration of Hospital Confinement, Was Surgery Done?, Degree of Recovery, Name and Address of Hospital and/or Doctor

Complete only if policy to be reinstated is Association Group or Franchise:

I certify that I still belong to the _____ (Full Name of Organization)

Date joined _____

My relationship to above organization: () Employee () Dues-paying Member
() Shareholding Member () Other

I represent that my above answers and statements are true and complete to the best of my knowledge and belief.

If agent submitted:

I/We represent that during an in-person interview with the proposed applicant I/we have truly and accurately recorded in this application the information supplied by the applicant.

(Agent Stamp)

(Signature of Agent)

Dated at _____
(City)

_____ on _____, _____
(State) (Month) (Day)

(Signature of Applicant for Reinstatement)