



Medicare Supplement Premium Payment List-Bill Program

List-Bill Enrollment Form

This List-Bill Enrollment Form may be used for plans involving: (i) pension deductions; (ii) employer contributions and/or (iii) direct bill by a third-party list-bill administrator to individuals in this Medicare Supplement Premium Payment List-Bill Program (this "Program"). All Program participants will be on one bill.

The following sections must be completed to set up a list-bill group. Please print.

Name of Employer _____ Phone No. (_____) _____

Business Address _____

City _____ State _____ ZIP _____

Nature of Business _____ SIC _____

Date Business Was Established _____

Name of List-Bill Administrator _____ Phone No. (_____) _____
(if other than employer)

E-mail Address _____ Facsimile No. (_____) _____

Business Address _____

City _____ State _____ ZIP _____

Billing Address if Other Than Business Address _____

City _____ State _____ ZIP _____

EMPLOYER/LIST-BILL ADMINISTRATOR ACKNOWLEDGEMENTS:

Until further notice, the undersigned ("We," "Our") will honor the list-bill requests made by retirees for payments to Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, and United World Life Insurance Company (collectively, "Mutual of Omaha").

By signing this List-Bill Enrollment Form, We acknowledge and agree that Mutual of Omaha will issue an individual policy to each approved applicant. Such individual contract is not part of a group health or life insurance plan and no group contract will be issued. Participation in this Program is completely voluntary. Any contribution to premiums or conduct beyond pension deduction services by the employer may make this Program subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) and may subject the employer to ERISA and other state and federal laws. An employer contributing to premiums paid by its retirees should seek legal and tax guidance for compliance with applicable laws and regulations as they relate to this List-Bill Enrollment Form.

We agree to hold harmless and indemnify Mutual of Omaha from any and all liability, including attorneys' fees and costs, which it may incur due to contributions to premiums by the employer.

Signature of Authorized Representative of Employer or List-Bill Administrator*

Name of Employer or List-Bill Administrator (Please Print)

Authorized Representative's Position or Title

Date

*Signature of employer is required if employer will provide pension deduction services or if employer will make contributions to the premiums on behalf of its retirees.

Existing Coverage

This Section To be Completed by Producer:

1. What type of coverage do the proposed Program participants currently have?

2. Is the existing coverage an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays? If yes, answer questions (a) or (b) Yes No

(a) Are the retirees voluntarily leaving the group plan? Yes No

(b) Is the coverage ending? Yes No

3. Is the existing coverage a group Medicare supplement policy with individual certificates issued to retirees? If yes, answer questions (a) or (b) Yes No

(a) If yes, are the retirees voluntarily leaving the group plan? Yes No

(b) If yes, is the coverage ending? Yes No

4. Is the existing coverage an individual Medicare Supplement policy where the employer contributes in the form of a stipend to the retiree or by directly paying some or the entire premium? Yes No

If the answers to questions 2(b) or 3(b) are "Yes," please include a copy of the termination letter with this List-Bill Enrollment Form.

Producer Information

Producer Name

Producer Number

Telephone Number

Facsimile Number

E-mail Address

Mailing Address

City

State

ZIP

Name of Manager/MGA

Please check one box below to select recipient of first bill and welcome package:

Producer

Employer

Third-party List-Bill Administrator

Initial Enrollment Form for List-Bill Applicants

These sections must be completed for all new list-bill groups. (Enrollment data may be included on a separate sheet attached to this form.)

Estimated number of initial applications _____

In order to establish a list bill for individual Medicare Supplement benefits, a minimum of three (3) individuals must participate.

PLEASE NOTE: No applications need to be submitted with this List-Bill Enrollment Form. Once this form is received and processed, the producer will receive an assigned group number which should be listed on the individual applications for that group. The initial set of applications for the group should be submitted to Mutual of Omaha using the same submission process used for individual application submission today.

No.	Last Name	First Name	Date of Birth	State of Residence
1				
2				
3				
4				
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List-Bill Invoice Cycle and Desired Coverage Effective Date

Please check one box below to select a billing cycle. This List-Bill Enrollment Form will not be accepted if no selection is made.

- Monthly
- Quarterly
- Semi-Annual
- Annual

Desired Coverage Effective Date _____

Guidelines for Establishing a List-Bill Account

Overview

This form may be used for situations involving an employer or third-party administrator where premium payment for participants will be through list bill. All Program participants will be on one statement that will be sent to the entity that is administering the Program on behalf of the participants. The list-bill statement will be sent three (3) weeks prior to the premium due date. It is the responsibility of the administrator to remit the amount due for the Program by the due date and coordinate premiums among the Program participants. This completed enrollment form should be mailed or faxed to Mutual of Omaha using the following contact information:

Mail: Mutual of Omaha
3 - VIP Services
Mutual of Omaha Plaza
Omaha, NE 68175-3205

Fax: 1-866-613-8961

A customer service representative will inform the producer of the group number assigned to the Program. That group number should be noted on each individual application for the initial set of applications as well as any future add-ons to the Program. The initial set of applications should then be sent to Mutual of Omaha using the same application submission process that producers use today.

Adding An Individual to Existing List Bill Account

To add an individual to the list-bill account:

1. Meet with the individual to complete the application.
2. Submit the application for home office processing. Be sure to enter the group number on the application.

Removing An Individual from Existing List Bill Account

To remove an individual from the list-bill account, follow the directions on the list-bill statement.

Canceling Entire List-Bill Account

To cancel entire list-bill account, the employer or third party list-bill administrator must provide thirty (30) days prior written notice to all individuals on the list-bill account and to Mutual of Omaha. Employer or third party list administrator is responsible for coordinating any return of premiums that may be necessary.

Help

Contact a customer service representative at 1-800-877-1050 with list bill set up or enrollment questions.

Minimum Requirements to Establish a List-Bill Account

In order to establish a list bill for individual Medicare supplement benefits, a minimum of three (3) or more individuals must participate in the program.