LONG-TERM CARE INSURANCE

MutualCare® Solutions PRODUCT GUIDE

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Mutual of Omaha

454000

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MutualCare® Solutions

MutualCare® Solutions is a portfolio of LTCi products developed to address the needs of a changing LTCi marketplace. Since it was first introduced, long-term care insurance has continued to evolve and change. What started as nursing home-only coverage now offers insureds the flexibility to receive care in a variety of settings, including in their homes.

MutualCare® Solutions is the next generation of long-term care insurance products designed to provide the asset protection a whole new generation of Americans need while maintaining the viability and sustainability of the product line for years to come.

The MutualCare® Solutions portfolio includes two long-term care insurance policies: MutualCare® Secure Solution and MutualCare® Custom Solution.

MutualCare® Secure Solution is a traditional long-term care policy that allows people to plan ahead for their long-term care needs. By adding this measure of security to their retirement portfolio, they know that a portion of their long-term care expenses will be covered. MutualCare® Secure Solution is perfect for:

- Customers who are looking for easy-to-understand benefits and the security of knowing they have some measure of asset protection
- Agents who like a product with a simple design and traditional benefits

MutualCare® Custom Solution is a different approach to structuring policy benefits. It provides the flexibility to manage long-term care expenses and control how the dollars in the long-term care "account" are spent. MutualCare® Custom Solution is perfect for:

- Customers who want to customize a policy to fit their own unique needs
- Agents who are looking for a product with a strong premium solve capability

Portfolio Overview

In creating MutualCare® Solutions, we took the features you told us you like (our cash benefit is one) and found a way to make two great new product options.

This chart gives you an overview of products in the MutualCare® Solutions portfolio and allows you to clearly see the differences...and the similarities.

	MutualCare® Secure Solution	MutualCare® Custom Solution
Issue Ages	30-79*	
Tax Status	Tax Qualified Only	
Partnership Qualified (based on state approval, age of the applicant and inflation option selected)	Yes	
Built-In Benefits		
Policy Limit	Benefit multiplier determines policy limit (benefit multiplier x maximum monthly benefit = policy limit) Options include 24, 36, 48 or 60 months	Pool of dollars determines policy limit Options include $50,000 to $500,000 in $500 increments
Maximum Monthly Benefit	$1,500 to $10,000 per month in $1 increments	$1,500 to $10,000 per month in $50 increments (Subject to monthly benefit and policy limit combinations)
Calendar Day Elimination Period	90, 180 or 365 calendar days	0, 30, 60, 90, 180 or 365 calendar days
Cash Benefit	25% of home health care benefit up to initial maximum of $2,000 per month	25% of home health care benefit up to initial maximum of $2,000 per month
Nursing Home Benefit	100%	
Assisted Living Facility Benefit	50%, 75% or 100% of maximum monthly benefit	
Home Health Care Benefit	50%, 75% or 100% of maximum monthly benefit	
Adult Day Care Benefit	Up to 100% of the monthly home health care benefit	
Stay-at-Home Benefits • Caregiver Training • Durable Medical Equipment • Home Modification • Medical Alert System	Up to two times the maximum monthly benefit	
Bed Reservation Benefit for Nursing Home & Assisted Living Facility	30 days per calendar year	
Respite Care Benefit	1 month per calendar year; no elimination period applies	
Hospice Care Benefit	Pays maximum monthly benefit; no elimination period applies	
International Benefit	Maximum monthly benefit for up to 12 months	

*New York issue age 30-75.

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	MutualCare® Secure Solution	MutualCare® Custom Solution
Waiver of Premium • Nursing Home • Assisted Living Facility • Home Health Care	Included; subject to eligibility requirements	
Alternate Care Benefit	Available when care coordination is used	
Contingent Nonforfeiture Benefit (unless replaced by Nonforfeiture – Shortened Benefit Period)	Default	
Optional Partner* Benefits		
Shared Care	Available	
Security Benefit	Available	
Joint Waiver of Premium	Not Offered	Available
Survivorship Benefit	Not Offered	Available
Other Optional Benefits		
Waiver of Elimination Period for Home Health Care	Available	
Nonforfeiture – Shortened Benefit Period (removes Contingent Nonforfeiture built into policy)	Available	
Return of Premium at Death (less claims paid) – Three Times Initial Maximum Monthly Benefit	Available	
Return of Premium at Death (less claims paid)	Not Offered	Available
Return of Premium at Death (less claims paid) – If Death Occurs Before Age 65	Not Offered	Available
Professional Home Health Care	Not Offered	Available
Inflation Protection Options		
Inflation Protection Options	Lifetime: 3%, 4%, or 5% compound 20-Year: 3% or 5% compound No inflation protection	Inflation Percentage: 1% to 5% compound in .25% increments Inflation Duration: Lifetime, 20, 15 or 10 years No inflation protection
Inflation Protection Buy-Up Option	Not Offered	Available
Premium Allowances		
Partner* • Both Issued • One Issued	15% 5%	
Preferred	15%	
Association/Sponsored Group	5%	
Producer	5%	
Common Employer	5%	
Premium Payment		
Lifetime	Default	

*Partner is defined as spouses who are legally married, domestic or civil union partners, or adults in a serious, committed personal relationship intended to be lifelong who have shared a common residence for the most recent three years, are not married to or a domestic or civil partner of anyone else, and are not related in any way that would bar marriage.

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Benefit Descriptions

We know you may need a little help remembering all the details of how our products work. So here's a brief description of all the benefits available.

✔ Indicates benefits that are built into the base policy
✚ Indicates optional benefits that are available at an additional cost

A

✔ Alternate Care Benefit

We know there may be long-term care services or treatments that don't exist today yet may become standard practice in the future. This benefit provides coverage for qualified treatments or services not specifically listed in the policy when recommended by a care coordinator.

Note: The Alternate Care Benefit may cover the services of a Christian Science provider when the insured is eligible to receive Alternate Care benefits under the policy. Here's how it works:

- Services must be provided by an accredited Christian Science nurse as listed in the Christian Science Journal; and
- Services must be incurred while confined in a Christian Science nursing organization/facility currently recognized by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., or any comparable accrediting organization

✔ Assisted Living Facility Benefit

The policy provides options for the insured to receive 100 percent of the maximum monthly benefit (with the option to reduce to 75 percent or 50 percent) to help pay for services received in an assisted living facility.

B

✔ Bed Reservation Benefit for Nursing Home & Assisted Living Facility

This benefit comes into play when the insured is confined to a nursing home or assisted living facility. Under this provision, the policy will pay up to 100 percent of the maximum monthly benefit for up to 30 days per calendar year to keep a bed available in the insured's facility until he or she returns.

C

✔ Care Coordination Benefit

Our policies offer the optional services of a care coordinator who will assess the needs of the insured, develop an individualized plan of care and help arrange for long-term care services. Here's how it works:

- There's no elimination period to satisfy, which gives the insured immediate access to the services of a care coordinator
- Care coordinators are licensed health care professionals – typically registered nurses
- The use of a care coordinator is not required; however, some policy benefits are available only when a care coordinator is used
- Upon the recommendation of a care coordinator, the policy will pay a maximum limit of up to two times the home health care maximum monthly benefit for the following stay-at-home services:
  - Caregiver training
  - Durable medical equipment
  - Home modifications
  - Medical alert system

✔ Cash Benefit

The Cash Benefit is designed to give the insured – and his or her family – the ability to explore care options when the need for long-term care first arises. A percentage of the home health care maximum monthly benefit amount is available in cash to help pay for any expenses related to the insured's long-term care needs. Here's how it works:

- There's no elimination period to satisfy in order to receive the Cash Benefit
- The Cash Benefit is paid in advance each month. If the insured is eligible for the Cash Benefit for less than an entire month, the benefit will be pro-rated based on the actual number of days the insured is eligible for the benefit in that month. (Note: It's assumed each month consists of 30 days regardless of the actual number of days)
- No other benefits are available under the policy while the insured is receiving the Cash Benefit
- The insured may switch from a Cash Benefit to a Reimbursement Benefit by notifying us in writing. The insured has the option to switch between Cash and Reimbursement Benefits at any time

- Once the Cash Benefit has ceased, the insured must satisfy the policy's elimination period in order for Reimbursement Benefits to begin
- Days in which the Cash Benefit is utilized do not count toward the elimination period for Reimbursement Benefits
- The Cash Benefit is not available for care received outside the United States, its territories, Canada or the United Kingdom

MutualCare® Secure Solution	MutualCare® Custom Solution
Cash Benefit: • 25% of the home health care maximum monthly benefit, up to initial maximum of $2,000* per month	**Cash Benefit:** • 25% of the home health care maximum monthly benefit, up to initial maximum of $2,000* per month

*This amount may increase if inflation protection is added to the policy.

✔ Contingent Nonforfeiture Benefit

The Contingent Nonforfeiture Benefit provides the insured with coverage if he or she does not elect the Nonforfeiture Benefit – Shortened Benefit Period. This benefit will apply to the insured if and only if there is a substantial increase in the premium rate for their coverage. Insureds would then have the option to:

- Reduce their current level of coverage without evidence of insurability so that the required premium for their coverage is not increased or
- Convert their coverage to a paid-up status with a reduced policy limit

E

✔ Calendar Day Elimination Period

This waiting period represents the initial number of calendar days the insured must be chronically ill before benefits are payable under the policy. Here's how it works:

- If the insured is not receiving cash benefits, the elimination period begins on the first day he or she is chronically ill and receives a covered long-term care service
- Subsequent days during which the insured is chronically ill will be used to satisfy the elimination period, even if a covered service is not received on those days
- The elimination period is cumulative and needs to be satisfied only once during the life of the policy

- There is no elimination period to satisfy if the insured elects to receive the Cash Benefit; however, once the insured switches to a Reimbursement Benefit, an elimination period will apply
- A 90-day elimination period is the default option. Additional options may be elected
- Elimination periods available for Class I and Class II risks are limited to 90, 180 or 365 days

MutualCare® Secure Solution	MutualCare® Custom Solution
Elimination Period: • Options include 90, 180 or 365 calendar days	**Elimination Period:** • Options include 0, 30, 60, 90, 180 or 365 calendar days

H

✔ Home Health Care Benefit

Most people prefer to receive long-term care services at home. The insured will receive 100 percent of the maximum monthly benefit (with the option to reduce to 75 percent or 50 percent) to help pay for home health care services.

✔ Hospice Care Benefit

People who are terminally ill and not expected to live beyond six months need special care. The policy provides up to the maximum monthly benefit for hospice care services with no elimination period to satisfy.

I

✚ Inflation Protection

The cost of long-term care services is likely to be higher years down the road when the insured needs care. An optional inflation protection rider allows policy benefits to increase to assist with potential rising costs. Here's how it works:

- The current maximum monthly benefit and remaining policy limit increase annually by the percentage the insured selects
- The increase occurs on each policy anniversary date for the length of time the insured selects – either for the life of the policy or for a limited period of time

MutualCare® Secure Solution	MutualCare® Custom Solution
Lifetime: 3%, 4%, or 5% compound 20-Year: 3% or 5% compound No inflation protection	Inflation Percentage: 1% to 5% compound in .25% increments Inflation Duration: Lifetime, 20, 15 or 10 years No inflation protection Includes guaranteed buy-up option

✚ Inflation Protection Buy-Up Option

The insured may increase the percentage of inflation applied to policy benefits (not to exceed 5 percent) on or before each policy anniversary date. The increase is effective on the policy anniversary following the election, with benefit increases occurring the following anniversary. The increase is available prior to the lesser of 20 years or age 75 (cannot be chronically ill). Partnership qualification is determined on the inflation option effective issue. Partnership qualification cannot be gained by electing a buy-up of inflation after issue. Here's how it works:

- The buy-up option is only available on MutualCare® Custom Solution policies
- Each year, on or before the policy anniversary date, the insured can choose to increase his or her compound inflation protection to any percentage we offer. The insured must elect this option in writing
- The total level of inflation protection cannot exceed 5 percent
- The premium for the policy is based on the insured's age at the time of the buy up; however, actual premium will include a premium credit based on type of coverage and how long the policy has been in force
- The increase is effective on the policy anniversary following the election with benefit increases occurring on the following anniversary
- The increase is available prior to the lesser of 20 years or age 75
- The insured also has the option to buy down to a lower inflation percentage at any time while retaining any gains applied to the policy as a result of the inflation rider. Premium is based on the insured's age at policy issue and the policy's current rates

MutualCare® Secure Solution	MutualCare® Custom Solution
Not Offered	Available

✔ International Benefit

This benefit is available to an insured who may be confined to a nursing home or assisted living facility or is receiving home health care or adult day care outside the United States, its territories, Canada or the United Kingdom. Here's how it works:

- The International Benefit is equal to 12 times the maximum monthly benefit
- This benefit is paid regardless of the amount of incurred expenses in any given month (the incurred expense may be more or less than the maximum monthly benefit amount)
- No additional International Benefits are payable under the policy once the benefits paid equal the International Benefit lifetime maximum
- The Cash Benefit is not available in conjunction with the International Benefit

J

✚ Joint Waiver of Premium Benefit

This optional rider waives premium for both partners when one partner is on claim. Here's how it works:

- No premium will be due from the insured partner for as long as the other partner's premium is waived
- When the waiver period ends under the other partner's policy, premium payments for the insured partner will resume and must be paid to keep the policy in force
- If premiums increase after policy issue due to an increase or addition in coverage, the increased premium must be in effect for 10 years or more before the increased amount will be waived
- This Joint Waiver of Premium Benefit is not available in conjunction with:
  - Security Benefit
  - Partner Premium Allowance (one issued)
- The Joint Waiver of Premium Benefit is not offered for Class I or Class II health risks

MutualCare® Secure Solution	MutualCare® Custom Solution
Not Offered	Available

M

✔ Maximum Monthly Benefit

This is the maximum dollar amount the policy will pay each month. Options range from $1,500 to $10,000 per month.

- $5,000 maximum allowed for Class I and Class II health risks
- The total long-term care coverage, including coverage from other companies, cannot exceed:
  - A Maximum Monthly Benefit of $10,000 and/or Maximum Benefit Limit of $500,000 for all traditional long-term care policy benefits combined; **and**
  - A Maximum Monthly Benefit of $50,000 and/or Maximum Benefit Limit of $2,000,000 for traditional long-term care and long-term care rider coverage benefits combined

Please Note: When providing prior or existing coverage information, the benefit amount should reflect current coverage amounts, not the initial amount of coverage.

MutualCare® Secure Solution	MutualCare® Custom Solution
• Available in increments of $1	• Available in increments of $50 • Amounts range from 1% to 4% of the policy limit. For example: the monthly benefit on a $300,000 pool of dollars would range from $3,000 to $10,000

N

✚ Nonforfeiture – Shortened Benefit Period

This allows coverage to continue on a reduced basis in the event the insured stops paying premiums. Here's how it works:

- The policy must have been in force for three years in order for this provision to take effect
- This rider replaces the contingent nonforfeiture language in the policy
- The Nonforfeiture – Shortened Benefit Period rider MUST be offered. If it is not selected, the contingent nonforfeiture benefit becomes the default

✔ Nursing Home Benefit

Nursing home care is a very costly long-term care service. The policy provides 100 percent of the maximum monthly benefit amount to help pay for covered services received in a nursing home.

P

✔ Policy Limit

This is the maximum dollar amount payable over the remaining life of a policy. All benefits paid, except Care Coordinator and Waiver of Premium, will reduce the policy limit. The initial policy limit shown on the policy schedule may be adjusted if coverage is decreased or increased. If an optional inflation protection rider is attached to the policy, the remaining policy limit will be increased annually. The total long-term care coverage, including coverage from other companies, cannot exceed:

- A Maximum Monthly Benefit of $10,000 and/or Maximum Benefit Limit of $500,000 for all traditional long-term care policy benefits combined; **and**
- A Maximum Monthly Benefit of $50,000 and/or Maximum Benefit Limit of $2,000,000 for traditional long-term care and long-term care rider coverage benefits combined

MutualCare® Secure Solution	MutualCare® Custom Solution
Uses a benefit multiplier to determine the initial policy limit (benefit multiplier x maximum monthly benefit = policy limit) • Options include 24, 36, 48 or 60 months • 60-month benefit multiplier and $5,000 monthly benefit is the maximum allowed for Class I and Class II health risks	Uses a pool of dollars to determine the initial policy limit • Options include $50,000 to $500,000 in $500 increments • $300,000 policy limit and $5,000 monthly benefit is the maximum allowed for Class I and Class II health risks

✚ Premium Allowances

We offer a variety of premium allowances that help people save money. The insured is eligible to receive one or more of the following premium allowances:

Partner* (both issued) – 15%	Partner* (one issued) – 5%
If both partners are issued long-term care insurance from Mutual of Omaha, they each receive a 15% premium allowance. • Available when both policies are issued under the same policy form/product • Any partner that was previously issued under a different policy form/product is not eligible for the Partner Allowance • **Please Note:** Allowances will not be applied retroactively to partners issued with different effective dates, and will apply beginning on the second partner's effective date • If one applicant cancels the contract and it results in a cancel back to issue or policy not taken, the 15% partner allowance will be replaced by the 5% Partner Allowance (one issued) • Not available with the Security Benefit	A 5% allowance is offered to an applicant whose partner is not issued long-term care insurance from Mutual of Omaha. • Includes any partner not meeting the criteria for Partner (both issued) • Not available with the Joint Waiver of Premium, Survivorship or Shared Care Benefits • Not available if an applicant and their partner no longer meet the definition of Partner* (for example, one partner is deceased on the date the policy is issued)
Preferred – 15%	**Producer – 5%**
A 15% premium allowance is offered to applicants who are in good health. • The Preferred Allowance will be applied at the discretion of the underwriter • Can be combined with all partner allowances	You and your partner are each eligible for a 5% premium allowance when you purchase this Mutual of Omaha long-term care insurance policy • Not available with Association/Sponsored Group or Common Employer Allowances
Association/Sponsored Group – 5%	**Common Employer** – 5%**
Applicants who are members of a qualifying association group are eligible for a 5% premium allowance. • Also applies to the partner of the insured • Includes a compensation offset • Not available with the Producer Allowance • Not available to add after issue	Five or more applicants who share a common employer all are eligible for a 5% premium allowance. • A minimum of five applications is required, must be initially submitted together • Once the five-person minimum is met, other employees of the same company also will receive the Common Employer Allowance • Cannot be employer paid or sponsored • PRD is not available • Not available with Association/Sponsored Group or Producer Allowances • Not available to add after issue

*Partner is defined as spouses who are legally married, domestic or civil union partners, or adults in a serious, committed personal relationship intended to be lifelong who have shared a common residence for the most recent three years, are not married to or a domestic or civil partner of anyone else, and are not related in any way that would bar marriage.

**Important Notice: This long-term care policy is not designed to be compliant with ERISA or Title VII or similar state laws and generally is not appropriate for an employer sponsored plan. Employers 'sponsorship' includes but not limited to: paying a portion of the premium, payroll deduction, list billing and endorsing or promoting the solicitation of the coverage during working hours. Please have your client's consult a legal or tax advisor or other qualified professional for more information.

✚ Professional Home Health Care

This optional rider makes additional benefits available when home health care services are provided by a nurse* or skilled professional specializing in physical, respiratory, occupational or speech therapy, audiology, nutrition or chemotherapy administration. If the cost of Professional Home Health Care services exceeds the home health care maximum monthly benefit in any given month, this benefit provides up to an additional 100 percent of the home health care maximum monthly benefit.

*Additional funds for home health care provided by a nurse are limited to 365 days over the life of the policy. This rider cannot be dropped after issue.

MutualCare® Secure Solution	MutualCare® Custom Solution
Not Offered	Available

R

✔ Respite Care Benefit

The policy pays for one month of respite care per calendar year. This benefit is intended to provide temporary services of another person or facility in order to give the insured's regular, unpaid caregiver a break from providing care.

✚ Return of Premium at Death (minus claims paid) – Three Times Initial Maximum Monthly Benefit

This optional rider returns up to three times the maximum monthly benefit of the policy, minus claims paid, upon the insured's death after the policy has been in force for a 10-year period. For the purposes of this rider, the maximum monthly benefit is the lesser of three times the initial maximum monthly benefit, or three times the current maximum monthly benefit, excluding the whole amount of any inflation protection increases that may have been received. This rider cannot be dropped after issue.

- Not available for applicants over age 64
- Not available with Shared Care

✚ Return of Premium at Death (minus claims paid)

This optional rider returns premium paid on the policy, minus claims paid, upon the insured's death. This rider cannot be dropped after issue.

- Not available for applicants over age 64
- Not available with Shared Care

✚ Return of Premium at Death (minus claims paid) – If Death Occurs Before Age 65

This optional rider returns premium paid on the policy, minus claims paid, if the insured dies before age 65. This rider cannot be dropped after issue.

- Not available for applicants over age 64

ROP Option	MutualCare® Secure Solution	MutualCare® Custom Solution
ROP – Three Times Maximum Monthly Benefit	Available	Available
ROP at Death	Not Offered	Available
ROP – If Death Occurs Before Age 65	Not Offered	Available

S

✚ Security Benefit

This optional rider provides an additional benefit without a reduction in the policy limit when the insured is receiving benefits and his or her partner is alive. The additional funds may be used to help pay for care or living expenses for an uninsured partner. Here's how it works:

- Pays the insured an additional 60 percent of the reimbursement benefit each month, excluding the cash benefit if any, for covered services received
- The Security Benefit will not reduce the policy limit
- The Security Benefit is only available with Partner (one issued) Allowance
- The Security Benefit is not offered for Class I or Class II health risks or for issue ages over age 69

✚ Shared Care Benefit

This optional rider allows one insured to access benefits under a partner's policy. Here's how it works:

- Benefits must be identical at the time of policy issue
- Once benefits have been exhausted under the insured's policy, but the need for long-term care services continues, he or she may access benefits under a partner's identical policy until a minimum of 12 times the current maximum monthly benefit remains
- If one partner dies while both policies are in force, the surviving partner will receive the deceased partner's remaining policy limit with no effect on the surviving partner's premium. If an inflation option was chosen, the new total amount will inflate accordingly
- The Shared Care Benefit is only available when both partners apply for coverage at the same time and are issued identical policies
- The Shared Care Benefit is not available with:
  - Security Benefit
  - Return of Premium at Death (minus claims paid)
  - Return of Premium at Death (minus claims paid) – Three Times Initial Maximum Monthly Benefit
  - Partner Premium Allowance (one issued)
- The Shared Care Benefit is not offered for Class II health risks or if Underwriting determines one or both applicants pose a greater than normal risk

MutualCare® Secure Solution	MutualCare® Custom Solution
Not offered to Class I health risks with: • A benefit multiplier greater than 36 months • A maximum monthly benefit greater than $5,000	Not offered to Class I health risks with: • A policy limit greater than $180,000 • A maximum monthly benefit greater than $5,000

✚ Survivorship Benefit

This optional rider allows an insured to have a paid-up policy in the event his or her partner dies. Here's how it works:

- If the insured's partner dies after the policy has been in force for 10 years or more, no further premium is due on the insured's policy
- If premiums increase after policy issue due to an increase or addition in coverage, the increased premium must be in effect for 10 years or more before the increased amount will be waived
- The Survivorship Benefit is not available in conjunction with:
  - Security Benefit
  - Partner Premium Allowance (one issued)
- The Survivorship Benefit is not offered for Class I or Class II health risks

MutualCare® Secure Solution	MutualCare® Custom Solution
Not Offered	Available

W

✚ Waiver of Elimination Period for Home Health Care

This optional rider enables the insured to receive home health care benefits without having to satisfy an elimination period. This rider cannot be dropped after issue. Here's how it works:

- Once expenses are incurred for covered home health care services or adult day care, the elimination period for home health care or adult day care will be waived
- Days on which the elimination for home health care is waived will be used to satisfy the elimination period for other benefits available under the policy. The elimination period for nursing home and assisted living will begin to be satisfied on a calendar-day basis
- This rider is not available for Class I or Class II health risks

✔ Waiver of Premium

This benefit means no premium is due while the insured receives covered long-term care services. Here's how it works:

- After the policy's elimination period has been satisfied, no further premium payments are required effective on the date benefits are first paid for nursing home, assisted living or at least eight days of home health care or adult day care in any continuous 30-day period
- Premium also is waived if the insured is receiving the cash benefit
- The premium payment mode does not affect the waiver of premium start date; however, any portion of premium paid beyond the start date will not be refunded. Instead, we will credit such premium to any future premium payments that come due
- Once the waiver of premium ends, the insured must resume premium payments to keep the policy in force

General Guidelines

The MutualCare® Solutions application packet contains the application plus all forms required in the applicant's state of residence. Follow these guidelines when submitting an application:

- **Use the correct application** – Be sure to use the most current application available for the client's state of residence in which federal taxes are paid. Non-resident state applications will not be accepted. You will be required to submit the correct state application before a policy can be issued
- **You must have the appropriate state license** – A producer cannot sell, solicit, or negotiate insurance in any state unless licensed in that state. You must be licensed in the state in which the application is signed. (A special note about Alabama, Alaska, Georgia, Idaho, Louisiana, Maine, New Hampshire, Puerto Rico and Kansas: For applications completed with residents in these states, you must be appointed in the applicant's resident state as well as the state where the application is signed.)
- **Only the applicant may sign** – Many long-term care sales are made to married couples. Keep in mind that each applicant is underwritten individually and, upon approval, both partners are issued their own policies. Only the applicant for insurance may complete and sign the application
- **White out is not allowed** – If a question is answered in error, draw a single line through the error and have the correction initialed by the applicant
- **Don't use "N/A"** – "N/A" is not an acceptable answer. Instead, use "no" or "none" when answering a question on the application
- **Consider including a quote** – Providing a copy of the quote when you submit the application packet is beneficial but not required
- **Watch the date** – Applications must be received by Mutual of Omaha within 30 days of the application date. Applications that are more than 30 days old will require you to submit a new, complete, currently dated application. Premium will be based on the applicant's age as of the new application signing date
- **Ownership** – Policyowner must be the proposed insured. Premium may be paid by a Trust, however, the Trust cannot own the policy
- **Subsequent applications** - Applications received within 3 months of the original application date will not be accepted. Applications received after the 3-month period will be handled as an Internal Replacement if the original policy is still in force.

Remember...

Your LTC training must be up-to-date or your application cannot be accepted.

Verify the correct Social Security number is filled out.

Write clearly as all items have to be entered into the underwriting system.

Verify the routing number and account numbers are correct for Automatic Bill Pay (verify with clients check).

Confirm and state if it is a checking or savings account for Automatic Bill Pay.

There are now two ways to submit long-term care business; traditional paper applications and via an electronic application. The e-app will allow you to complete and submit long-term care applications online. It will also ensure the application is completed in its entirety before submitted. Both applications can be found on Sales Professional Access (SPA).

Steps for Completing the Application

There's a lot to remember when completing an application. Here's a rundown of what you need to know so you don't skip a step.

Step 1: General Information
Make sure you answer all general information questions, including the best time to call the applicant. Be sure to tell the applicant that a representative will call them to schedule a telephone interview or a face-to-face interview.

Step 2: Premium Allowances
Answer all questions in the premium allowances section. Applicants may be eligible for premium allowances based on their answers.

Step 3: Replacement Coverage
Be sure to provide all requested information. If a Mutual of Omaha policy will replace an existing long-term care policy, replacement form(s) must be completed based on the applicant's state of residence and the prior coverage must be shown on the application. Remember the laws are strict regarding long-term care replacement.

Please Note: When providing prior or existing coverage information, the benefit amount should reflect current coverage amounts, not the initial amount of coverage.

Step 4: Health Insurability
Provide complete and accurate information about the applicant's health status (see the Health-Related Guidelines section for assistance). Also, be sure to include the address and phone number of the applicant's primary care physician. While answers to health insurability questions are verified via medial records and/or during the personal health interview, failure to disclose an existing condition can result in denial of a future claim related to that condition.

Step 5: Benefit Selection
Be sure to complete all appropriate sections.

Please Note:

- The total long-term care coverage, including coverage from other companies, cannot exceed:
  - A Maximum Monthly Benefit of $10,000 and/or Maximum Benefit Limit of $500,000 for all traditional long-term care policy benefits combined; **and**
  - A Maximum Monthly Benefit of $50,000 and/or Maximum Benefit Limit of $2,000,000 for traditional long-term care and long-term care rider coverage benefits combined
- The 5 percent compound lifetime inflation option must be offered to all applicants. If not elected, the applicant must check the "no" box in the inflation protection option section of the application. An inflation protection option or "no inflation" must be selected
- The Nonforfeiture – Shortened Benefit Period must be offered. If not chosen, the applicant must check the "no" box in the appropriate section of the application and the Contingent Nonforfeiture Benefit will become the default

Step 6: Premium Options
For Recurring Premium payment, indicate one of the following:

- Direct Bill
- Automatic Bill Pay

Also indicate premium mode desired and the modal premium amount.

Step 7: Effective Date
Indicate how the applicant wishes to have coverage issued, if approved. Options include:

- Date the policy is issued
- Requested effective date of coverage (for replacements only). This can be up to 60 days from the date the application is signed

For Policies with Shared Care: Effective date allowed to move up to 30 days following issue in order for both policies to share the same effective date.

Step 8: Notice Before Lapse or Termination
This section must always be completed. However, if the applicant does not wish to designate a person to receive a lapse or termination notice when payment is 30 days past due, he or she must check the appropriate box.

Step 9: Agreements and Acknowledgements
Have each applicant sign and date this section and include the city where the application was signed. Check the appropriate box and provide an explanation, if indicated. Then be sure to sign the application yourself.

Step 10: Authorization to Disclose Personal Information
This section gives Mutual of Omaha Insurance Company permission to obtain information needed to complete the underwriting process. Please make certain the applicant signs and dates this page. Failure to do so will result in processing delays and a non-issued policy.

Step 11: Producer Statement
Don't forget to complete this section. Be sure to include your contact information, or that of a designated contact, so we can reach you if we have questions or need additional information.

Please Note: We currently support a maximum of three producers completing this process.

Submitting the Application

Applications can be submitted through your normal channels or directly to our Long-Term Care Service Office, depending upon your currently established process.

General Mail:
Long-Term Care Service Office
P.O. Box 64901
St. Paul, MN 55164-0901

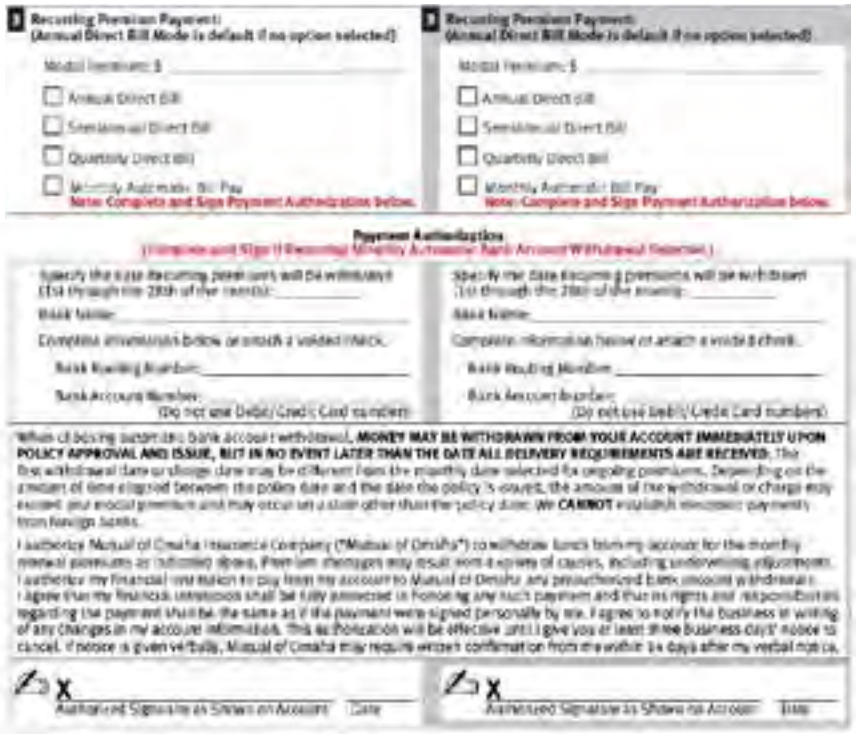
Applications may be submitted by fax to: 1-888-539-4672.

General Mail:
Mutual of Omaha
P.O. Box 30154
Omaha, NE 68103-1254

Expedited Mail:
First National Bank
Attn: Stop 2203
Box 30154
1620 Dodge St.
Omaha, NE 68197-2203

Recurring Premium Processing

For Recurring Premium Payment, indicate the premium mode desired and the modal premium amount.



Use the following modal factors to calculate premium:

Monthly Bank Draft	Quarterly	Semiannual	Annual
.09	.26	.51	1.00

If the applicant wishes to pay monthly premiums through the Monthly Bank Draft, the Recurring Premium Mode section of the application must be completed.

Note: The Automatic Bill Pay for recurring premium is only available through Monthly Bank Draft mode. The first premium payment will be drafted upon issue. All other modes for recurring premium payment will be through done through direct bill.

Recurring premium payments can be mailed to:

- General Mail: Mutual of Omaha
  P.O. Box 30154
  Omaha, NE 68103-1254
- Expedited Mail: First National Bank
  Attn: Stop 2203
  Box 30154
  1620 Dodge St.
  Omaha, NE 68197-2203

Missing Requirements

An application will be withdrawn within 90 days of receipt if an underwriting determination cannot be made due to missing requirements, including health interview, medical records or underwriter requested medical follow-up, or in the event application corrections have not been received.

- A case may be reopened if missing requirements are received within 90 days of the application signing date. The underwriter may request a Statement of Good Health or personal health interview. The original application and premium age will be used
- If requirements are received longer than 90 days after the application signing date, a new application and health interview will be required. Updated medical records also may be requested. Premium will be calculated based on the attained age of the applicant

Checking Case Status

Application and underwriting status is available on Sales Professional Access (SPA) – our secure agent website. Log in using your seven-digit production number. Select the "Reports" tab. Then select the link labeled "Med Supp, LTC, DI and Other Health Products" to view your case status report.

Appealing an Underwriting Decision

Applications that are declined and policies that are rated or issued other than applied for are eligible for reconsideration through an appeal process. To ensure privacy, the specific reason for a policy being declined or rated/issued other than applied for is shared only with the applicant. After reviewing the letter with the applicant please review the information in this guide for our handling of the applicant's condition(s). If the applicant disagrees with the specific reason given in the letter, he or she has the right to submit additional information. Here's how the appeal process works:

- Please contact the underwriter involved in the case in regard to what specific medical information would be needed to satisfy a successful appeal
- A notice of appeal, which includes additional information that may have a bearing on our decision must be submitted in writing by the applicant and/or his or her physician within 30 days of receipt of the letter (some states vary slightly). Informal (verbal) appeals will be considered at the request of General Managers, District Sales Managers and Brokerage Managers
- A decision letter will be sent to the applicant within 30 days of receipt of the appeal information
- The 30-day period for review of the policy and billing notice of premium due are independent of the appeal process. Partner policies also are independent of the appeal process and should be delivered accordingly
- The application date will determine whether the original application can be used along with a Statement of Good Health or if a new application will be required

Other Application-Related Questions

What if I have a non-English speaking applicant?
If you and the applicant are not fluent in the same language, an interpreter must be present to translate all questions and responses.

- It is the applicant's responsibility to have an interpreter available to meet with you when the application is completed. The applicant may choose an interpreter, but the interpreter cannot be a family member, beneficiary or someone who would benefit from the issuance of a policy. You may serve as an interpreter if you and the applicant are fluent in the same language
- In addition to questions on the application and the applicant's responses, the interpreter is required to translate all comments you make as well as information contained in marketing materials and forms
- With the assistance of an interpreter, you should ask the applicant to sign the application and the Producer or Witness Certification form
- Be sure to include a note with the application that a translator will be needed for the health interview and indicate what language

What's the process for non-witnessed applications?
Non-witnessed applications are those completed via mail, telephone or online. Only applications mailed in the United States will be accepted. As the agent, you must:

- Be licensed in the state where the application is signed
- Answer "no" to question 2 on the Producer Statement section of the application: "I certify that each question was asked exactly as written and recorded the answers completely and accurately in the presence of the Proposed Insured"
- Indicate how the application was completed. Use the line that reads, "If No, explain"

What about an applicant who is active duty military or traveling outside the United States?
All applicants must be in the United States to complete and sign the application, complete the health interview, have an established United States physician they have seen within the last 24 months and accept delivery of the policy. This includes members of the military and U.S. citizens traveling abroad. Those traveling to an OFAC sanctioned country (Office of Foreign Assets Control) are ineligible for coverage.

What if my client is a foreign national?
Foreign nationals must be living in the United States for at least 36 continuous months to be eligible for coverage. Also, policies will not be issued to those who do not have a valid "Green Card" (Permanent Resident Card Form I-551). If the applicant meets residency requirements, include the Foreign National and Foreign Travel Questionnaire with the application.

Policy Delivery

If you are delivering the policy direct to your client, be sure it's delivered timely. The policy includes a 30-Day Free-Look Period, which provides your client 30 days from the date of delivery to review the policy. If during that time your client is not satisfied with the policy, they may return it to you or to us. We will refund all premiums paid within 30 days of the return directly to the payer. The policy will then be considered never to have been issued.

Upgrades

The insured may apply for a currently marketed policy option or benefit increase at the time of sale or within 60 days of policy issue. If the upgrade is approved, the change will appear either on an updated Schedule of Benefits page or a re-issued policy bearing the same number as the initial policy. Premium for the upgrade will be based on the applicant's age at initial policy issue.

- A Benefit Change Request form must be signed and dated by both you and the applicant prior to processing
- A Statement of Good Health form also is required

If the insured wishes to apply for an upgrade after the 60-day period, it is recommended that he or she retain the initial policy and apply for a second policy with the desired upgrades. Premium for the new policy will be based on the insured's age at the time of application.

Delivery Requirements

The 3 categories of Post Issue Requirements (PIR) are: Amendments, Premium, and Policy Delivery Acknowledgement forms. A policy may include any or all of these requirements.

Questions regarding delivery requirements can be directed to your case manager or the New Business Hotline at 800-275-5528.

Signed application amendments and delivery acknowledgement submission:

- Fax: 888-539-4672
- General Mail: Long-Term Care Services Office
P.O. Box 64901
St. Paul, MN 55164-0901
- Expedited Mail: Long-Term Care Service Office
7805 Hudson Rd., Ste. 180
Woodbury, MN 55125-1591

Amendments

If a material answer or benefit of an application has changed, an application amendment will be included with the policy issue kit.

Policy Delivery Acknowledgements (IL, LA, NE, SD, WV)

- Policy Delivery Acknowledgements must be received within 30 days of policy issue for the states of IL, LA, WV
  - If the acknowledgement is not received within 20 days on policy issue, an email will be sent to the applicant with a DocuSign option for the Policy Delivery Acknowledgment
  - If the acknowledgement is not received within 25 days of policy issue, a new policy kit will be mailed to the applicant that contains a letter of acknowledgement and the requirement will be filled by delivery receipt from the mail carrier
- Policy Delivery Acknowledgements must be received within 60 days of policy issue for the states NE, SD
  - If the acknowledgement is not received within 50 days on policy issue, an email will be sent to the applicant with a DocuSign option for the Policy Delivery Acknowledgment
  - If the acknowledgement is not received within 55 days of policy issue, a new policy kit will be mailed to the applicant that contains a letter of acknowledgement and the requirement will be filled by delivery receipt from the mail carrier

If recurring premium is submitted at the same time of any PIR, premium must be sent separately to:

General Mail: Mutual of Omaha
P.O. Box 30154
Omaha, NE 68103-1254
Expedited Mail: First National Bank
Attn: Stop 2203
Box 30154
1620 Dodge St.
Omaha, NE 68197-2203

Premium

The insured has 65 days from date of policy issue to pay his or her premium before the policy will lapse. The company will send the insured written notice 30 days after policy issue date if the premium is due and unpaid.

**Please see premium processing section for expanded premium guidelines.

Downgrades

Benefit decreases are allowed. If the decrease is requested within 60 days of the original effective date, it will be effective on the original effective date. If the decrease is requested after the 60-day period, the effective date of the change is the next renewal date following approval of the decrease. The decrease will appear either on an updated Schedule of Benefits page or a re-issued policy bearing the same number as the initial policy. Continuing benefits will keep the original issue age and will continue to earn renewal compensation.

Drop Coverage	Reduce Coverage
Allowable Features: • Inflation Protection • Nonforfeiture – Shortened Benefit Period • Survivorship Benefit • Joint Waiver of Premium • Shared Care Benefit (if partner's benefits have not been accessed) • Security Benefit	**Allowable Reductions:** • Inflation Protection Percentage* • Maximum Monthly Benefit • Policy Limit **Allowable Increase:** • Elimination Period
Subject to rider termination provisions	Subject to rider termination provisions

*Applies to inflation percentage only, inflation duration cannot be reduced.

Reinstatements

An insured may be eligible for policy reinstatement if his or her attained age is within current product age eligibility and the policy has been lapsed for less than 180 days.

- The insured must contact Customer Service to initiate reinstatement. They will be asked to complete an application
- At underwriter discretion, a current telephone interview and medical records may be required
- If reinstatement is approved, the insured must pay all back premium within 35 days of reinstatement approval. If not received in that time frame, the insured will become ineligible for reinstatement and will be required to reapply for coverage at his or her current age
- Reinstatement is not available when the policy is terminated as of the effective date
- To be eligible for reinstatement there must have been coverage in force and premium paid

Licensing and Appointments

Non-appointment states (all states except MT, OK & PA)

- If you are properly licensed in your state, you may solicit business prior to becoming appointed with Mutual of Omaha
- Applications must be submitted along with contracting paperwork
- Policies cannot be issued until the effective date of your appointment

Pre-appointment states (MT, OK & PA)

- You must be properly licensed and appointed with Mutual of Omaha BEFORE soliciting business
- If an application is dated prior to your appointment effective date, it will be rejected and a letter will be mailed to the applicant

Note: Pre-appointment requirements do not apply to agents holding a broker license.

Background Checks

All new agents are subject to a background check, which includes:

- Credit history
- Insurance department actions
- Federal and county criminal records

Be sure to disclose all information and answer each question on the information sheet truthfully. If answering "yes" to any question, an explanation (signed and dated by you) and any supporting documentation must accompany the contracting paperwork.

- Background checks are conducted by an outside entity and typically take three to five business days. If an issue is found, you will be contacted to resolve it, if possible
- No information regarding the finding of the background check can be discussed with your MGA
- If Mutual of Omaha declines to appoint you, both you and your MGA, if applicable, will be notified in writing
- All existing agents must have a background check when an appointment is added or if the last background check is more than two years old

Note:

It's nearly impossible to get an agent approved if something turns up on the background check that was not disclosed.

Errors and Omissions Insurance

Proof of Errors and Omissions insurance in the amount of $1,000,000 per claim is required for all Mutual of Omaha Insurance Company products.

Long-Term Care Training

Training is required in order for you to sell long-term care insurance and/or partnership-qualified policies in states where partnership programs are approved. Contact your state Department of Insurance for more information on partnership requirements in your state. Remember, you must take the required refresher course to keep your training up to date.

Mutual of Omaha has joined forces with LTCiTraining.com to bring you the industry's most comprehensive partnership training courses.

- Developed by industry expert, Phyllis Shelton
- Meets mandated NAIC and Deficit Reduction Act partnership training requirements
- ClearCert certified
- Technical support provided
- Training can be accessed through Sales Professional Access (SPA)

General Partnership Requirements

- **Licensing** – A producer cannot sell, solicit, or negotiate insurance in any state unless licensed in that state. You must be licensed in the state where the applicant is physically located at the time of the partnership-qualified sale. (If the applicant is a resident of Alabama, Alaska, Georgia, Idaho, Louisiana, Maine, New Hampshire, Puerto Rico and Kansas, you also must be licensed in the applicant's state of residence regardless of where the sale is made.)
- **Training** – You must have completed partnership training for the state in which the application is signed. (In Alabama, Alaska, Georgia, Idaho, Louisiana, Maine, New Hampshire, Puerto Rico and Kansas, you also must have completed partnership training for the state in which the client resides.) Reciprocity rules will apply. Training must be completed prior to the date the application is signed or the application cannot be accepted
- **Application** – You must use the application for the state in which the client resides

Long-Term Care Continuing Education

Your state may require long-term care continuing education. Please contact your state's Department of Insurance for more information.

Common Employer Referral Program

Targeting people with a common employer is a good way to generate multiple sales with minimal effort. It's easier than a true multi-life sale because there's no group approval to obtain. So when you're asking for referrals, be sure to ask prospective clients for names of co-workers.

Common Employer Referral Premium Allowance
When five or more employees who work for a common employer purchase a long-term care policy from you, they each save 5 percent on their premium. Here's how it works:

- Complete the Common Employer information in the allowance section of the application. There is also an indicator on page 1 of the application to help our service representatives look for this information
- Submit the Common Employer Questionnaire as a cover sheet along with the initial five applications. Be sure to include the names of all applicants plus the name of their common employer
- Subsequent applications can be submitted under the common employer referral program. Just indicate the common employer group number on all subsequent applications
- The Common Employer referral allowance is available to the employee and his or her partner

Important Notice: This long-term care policy is not designed to be compliant with ERISA or Title VII or similar state laws and generally is not appropriate for an employer sponsored plan. Employers 'sponsorship' includes but not limited to: paying a portion of the premium, payroll deduction, list billing and endorsing or promoting the solicitation of the coverage during working hours. Please have your client's consult a legal or tax advisor or other qualified professional for more information.

If the Common Employer Cover Sheet is not submitted, applications are likely to be processed without the Common Employer allowance or they will be returned to you to resubmit when the five-application minimum is met.

Understanding the Long-Term Care Claims Process

When the need for long-term care services arises, the agent is often the first person a policyholder contacts. That's why it's important for you to know how the claims process works in order to understand your role.

Step 1: Making initial contact
Mutual of Omaha's claims department wants to be notified as soon as possible when it's believed there may be a need for long-term care services. There are two ways the initial contact can be made:

- The insured may contact you. If you are the first point of contact, please notify the claims department as soon as possible to let us know a claim is coming
- The insured can contact Mutual of Omaha's claims department directly during normal business hours. The appropriate phone number is listed in the policy

Step 2: Gathering information
Once we receive the initial notification, a representative from Mutual of Omaha's claims department will talk with the insured to gather more information. We'll send the insured a claims packet that includes the claim form and a list of documentation needed to evaluate the claim and determine eligibility. This may include things like medical records and provider bills:

Medical Records
We may need to contact medical providers to collect additional information that can help us determine the need for long-term care services and eligibility for benefits under the policy.

Provider Bills
We'll ask the insured to submit bills for any expenses they may have already incurred to determine if those services are covered under the policy.

Step 3: Explaining how the policy works
Not all long-term care insurance policies are the same, so a claims representative will explain the benefits of the policy to the insured. This may include:

- Elimination period
- Care coordination services
- Payment of benefits
- Waiver of premium

Elimination Period
There are two different types of elimination periods – calendar day and service day. A claims representative will explain which type of elimination period the policy contains. For example:

- 90 calendar days means the waiting period begins the first day covered services are received and ends 90 days later
- 90 service days means the waiting period begins the first day covered services are received and ends after services are received for 90 days (not necessarily consecutive days)

Care Coordination Services
If the policy includes the services of a care coordinator, the claims representative will explain how this provision works. A care coordinator is a licensed health care professional – typically a registered nurse – who will work with the insured to develop an individualized plan of care, help to arrange for long-term care services and monitor the care the insured receives.

Keep in mind there's usually no elimination period for care coordination. That means if the policy contains a care coordination provision, the insured may have immediate access to the services of a caring professional who will work closely with them to ensure care needs are met.

Payment of Benefits
Some policies may contain an option that allows insureds to choose how they prefer to receive policy benefits. If the policy contains this option, the insured can elect to receive either a cash benefit or a reimbursement benefit.

- A cash benefit is a percentage of the policy's maximum monthly benefit amount and is payable each month the insured is eligible for benefits. There's no elimination period to satisfy, and the cash can be used to pay any long-term care related expense
- A reimbursement benefit simply reimburses the insured for actual long-term care expenses incurred, up to the maximum daily or monthly benefit provided by the policy

Waiver of Premium

The policy may contain a waiver of premium benefit, which means the insured won't have to make premium payments while receiving benefits. However, it's important for the insured to continue paying premiums until notified that no further premium is due.

Step 4: Determining benefit eligibility

Each policy states how the insured is eligible for benefits. For example, the policy may state that a licensed health care practitioner must submit a plan of care certifying the insured is chronically ill. That means for a period of at least 90 days, he or she needs help with two or more activities of daily living (bathing, dressing, eating, transferring, toileting and continence) or requires continual supervision due to a severe cognitive impairment.

Typically, it takes approximately 10 business days to determine eligibility, providing we have access to all the information we need. Once eligibility has been confirmed, we'll notify the insured or their representative/power of attorney.

If it's determined the insured is not eligible for benefits at this time, we'll send a letter explaining the decision and detailing the options. Keep in mind that the insured's health situation and need for care may change quickly, which means that even if they're not eligible for benefits initially, they may become eligible at a later date. If their condition worsens, we ask that they contact the claims department to re-evaluate their claim.

Step 5: Paying the claim

After satisfying the policy's elimination period,* the insured will become eligible to receive benefit payments. Once an eligible expense is received, it takes approximately 10 business days to approve it and issue a payment. Payment can be sent directly to the insured, to his or her representative/power of attorney or to any long-term care service provider designated by the insured (i.e., a nursing home).

Each time a bill is submitted for reimbursement and a claim is paid, the insured will receive an explanation of benefits (EOB) statement showing the amount of the maximum lifetime benefit paid to date. This allows the insured to track benefits that have been paid and to calculate the remaining benefit amount.

*Remember if the policy includes a cash benefit and that option is elected, there is no elimination period to satisfy.

The Role of the Agent

If you become aware of a potential claim, be sure to notify us as soon as possible. Please use this checklist to provide the following information about your client:

- ☐ Name
- ☐ Phone number
- ☐ Mailing address (so we can send a claims packet)
- ☐ Email address
- ☐ Policy number
- ☐ Policyholder's representative/power of attorney
- ☐ Type of claim (i.e., home health care, assisted living, nursing home)

Remember…as an insurance agent, **you may not act on behalf of your client** unless you are authorized to do so. HIPAA regulations require that all claims dealings must be between Mutual of Omaha and the insured or his or her representative/power of attorney.

Claims Department Contact Information

There are different phone numbers based on the type of policy the insured owns. Please be sure to use the correct number.

Legacy Policies (policies sold from 1987 to 2004)
Phone: 800-268-6443
Hours: Monday-Thursday: 7 a.m. – 5:30 p.m. CST
Friday: 7 a.m. – 5 p.m. CST

Modern Policies (LTC04 and later; modern policies have 33-xxxxxx numbers)
Phone: 877-894-2478
Hours: Monday-Friday: 7 a.m. – 5 p.m. CST

Contact Information

Fax Numbers & Email:

1-888-539-4672

epsupport@ltcg.com
- New application submissions

1-402-550-1926
- Missing application requirements
- Case Manager requests
- Authorizations

1-952-833-5410
- Delivery receipt/PDAs
- Change form requests
- Amendments

1-888-441-5824
- Claims

Mailing Addresses:

Long-Term Care Service Office
P.O. Box 64901
St. Paul, MN 55164-0901

- Application submission
- Post-issue requirements (amendments, delivery receipts)
- Coverage changes
- Cancellation requests

Long-Term Care Service Office
7805 Hudson Road, Ste. 180
Woodbury, MN 55125-1591

- Overnight application submission only

Sales Support Agency: 1-877-617-5589 Brokerage: 1-800-693-6083

sales.support@mutualofomaha.com

Hours: 8:00 a.m. to 4:30 p.m. CT
- Appointments
- Contracting
- Licensing
- Proposals
- Sales and product support
- Marketing material

Case Management

1-800-275-5528
Hours: 8 a.m. to 4:30 p.m. CST
- To identify, refer to welcome email
- New business service and status

Underwriting 1-800-551-2059

ltcunderwriting@mutualofomaha.com

Hours: 8 a.m. to 4:30 p.m. CT
- Underwriting risk selection
- Pre-screen health conditions not available in our underwriting guide

Long-Term Care Customer Service 1-877-894-2478

Hours: 7 a.m. to 5 p.m. CT
- Policy issue
- Customer service
- Billing and collection
- Claims

Why Mutual of Omaha

Over 50 years of Mutual of Omaha's Wild Kingdom taught us that the animal kingdom and the human kingdom have something in common ... an instinct to protect what matters most. Through insurance and financial products, we help people protect their lives, protect their families, protect their kingdoms.

MutualofOmaha.com

Mutual of Omaha