United of Omaha Life Insurance Company

RFP 5953 Z1
Original Document
December 12th, 2018

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Contract Services
Form

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the bidder guarantees compliance with the procedures stated in this Request for Proposal, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

SRS NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this RFP.

SRS I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

SRS I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	United of Omaha Life Insurance Company
COMPLETE ADDRESS:	Mutual of Omaha Plaza, Omaha NE 68175
TELEPHONE NUMBER:	(800) 655-5142
FAX NUMBER:	(402) 351-8565
DATE:	December 12th, 2018
SIGNATURE:	Sinaro Skold
TYPED NAME & TITLE OF SIGNER:	Sinaro Reang Skold, Lead Sales Analyst

Request for Proposal
Form

Form A
Bidder Contact Sheet
Request for Proposal Number 5953 Z1

Form A should be completed and submitted with each response to this RFP. This is intended to provide the State with information on the bidder's name and address, and the specific person(s) who are responsible for preparation of the bidder's response.

Preparation of Response Contact Information	
Bidder Name:	United of Omaha Life Insurance Company
Bidder Address:	Mutual of Omaha/Omaha Group Office 11605 Miracle Hills, Drive, Suite 101 Omaha, NE 68154
Contact Person & Title:	Christy Lemmer, Sr. Renewal Executive | Sinaro Skold, Lead Sales Analyst
E-mail Address:	christy.lemmers@mutualofomaha.com | sinaro.reang@mutualofomaha.com
Telephone Number (Office):	(402) 255-1636 | (402) 255-1617
Telephone Number (Cellular):	(402) 216-2518 | (402) 450-5602
Fax Number:	(402) 255-1600

Each bidder should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the bidder's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Bidder Name:	United of Omaha Life Insurance Company
Bidder Address:	Mutual of Omaha/Omaha Group Office 11605 Miracle Hills, Drive, Suite 101 Omaha, NE 68154
Contact Person & Title:	Christy Lemmer, Sr. Renewal Executive | Sinaro Skold, Lead Sales Analyst
E-mail Address:	christy.lemmers@mutualofomaha.com | sinaro.reang@mutualofomaha.com
Telephone Number (Office):	(402) 255-1636 | (402) 255-1617
Telephone Number (Cellular):	(402) 216-2518 | (402) 450-5602
Fax Number:	(402) 255-1600

State of Nebraska State Purchasing Bureau
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

RETURN TO:
State Purchasing Bureau
1526 K Street, Suite 130
Lincoln, NE 68508
Phone: 402-471-6500

SOLICITATION NUMBER	RELEASE DATE
RFP 5953 Z1	November 1, 2018
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
December 5, 2018 at 2:00 p.m. Central Time	Teresa Fleming

PLEASE READ CAREFULLY!

SCOPE OF SERVICE

The State of Nebraska (State), Department of Administrative Services (DAS), Materiel Division, State Purchasing Bureau (SPB), is issuing this Request for Proposal (RFP) Number 5953 Z1 for the purpose of selecting a qualified Bidder to provide Life Insurance Plans to be provided to State of Nebraska employees. A more detailed description can be found in Section V. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will be commencing upon execution of the contract by the State and the Bidder (Parties)/notice to proceed through June 30, 2023. The Contract includes the option to renew for two (2) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: http://das.nebraska.gov/materiel/purchasing.html.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the RFP, and the successful bidder's *proposal or response will be* posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all proposals or responses received regarding this RFP will be posted to the State Purchasing Bureau public website.

These postings will include the entire proposal or response. Bidders must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate container or envelope marked conspicuously in black ink with the words "PROPRIETARY INFORMATION". The bidder must submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE BIDDER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will then determine, in its discretion, if the interests served by nondisclosure outweighs any public purpose served by disclosure. (See Neb. Rev. Stat. § 84-712.05(3)) The Bidder will be notified of the agency's decision. Absent a State determination that information is proprietary, the State will consider all information a public record subject to release regardless of any assertion that the information is proprietary.

If the agency determines it is required to release proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this RFP for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this RFP, specifically waives any copyright or other protection the contract, proposal, or response to the RFP may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this RFP, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the RFP being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the RFP agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and

attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the RFP, awards, and other documents.

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

After Receipt of Order (ARO): After Receipt of Order

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the RFP. The State reserves the right to reject any or all proposals, wholly or in part, or to award to multiple bidders in whole or in part. The State reserves the right to waive any deviations or errors that are not material, do not invalidate the legitimacy of the proposal, and do not improve the bidder's competitive position. All awards will be made in a manner deemed in the best interest of the State.

Best and Final Offer (BAFO): In a competitive bid, the final offer submitted which contains the bidder's (vendor's) most favorable terms for price.

Bid/Proposal: The offer submitted by a vendor in a response to a written solicitation.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the vendor will not withdraw the bid.

Bidder: A vendor who submits an offer bid in response to a written solicitation.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or contract.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In

accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: Any individual or entity having a contract to furnish commodities or services.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining an offer after opening to determine the vendor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of bids/proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Installation Date: The date when the procedures described in "Installation by Contractor", and "Installation by State", as found in the RFP, or contract, are completed.

Interested Party: A person, acting in their personal capacity, or an entity entering into a contract or other agreement creating a legal interest therein.

Late Bid/Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Mandatory/ Must and Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of received, labeled, and sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Pre-Bid/Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the RFP, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: See Bid/Proposal.

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serves no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a RFP or resultant contract, brought by a vendor who has timely submitted a bid response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Release Date: The date of public release of the written solicitation to seek offers.

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Information (RFI): A general invitation to vendors requesting information for a potential future solicitation. The RFI is typically used as a research and information gathering tool for preparation of a solicitation.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Bidder: A bidder who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A bidder who has submitted a bid which conforms to all requirements of the solicitation document.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Sole Source – Commodity: When an item is available from only one source due to the unique nature of the requirement, its supplier, or market conditions.

Sole Source – Services: A service of such a unique nature that the vendor selected is clearly and justifiably the only practical source to provide the service. Determination that the vendor selected is justifiably the sole source is based on either the uniqueness of the service or sole availability at the location required.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subcontractor: Individual or entity with whom the contractor enters a contract to perform a portion of the work awarded to the contractor.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and sub-contractors or agents, and their employees. It shall not include any entity or person who is an interested Party to the contract or agreement.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product or service.

Vendor: An individual or entity lawfully conducting business in the State of Nebraska, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Vendor Performance Report: A report issued to the Contractor by State Purchasing Bureau when products or services delivered or performed fail to meet the terms of the purchase order, contract, and/or specifications, as reported to State Purchasing Bureau by the agency. The State Purchasing Bureau shall contact the Contractor regarding any such report. The vendor performance report will become a part of the permanent record for the Contractor. The State may require vendor to cure. Two such reports may be cause for immediate termination.

Will: See Shall/Will/Must.

Work Day: See Business Day

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The RFP is designed to solicit proposals from qualified Bidders who will be responsible for providing Life Insurance Plans to be provided to State of Nebraska employees at a competitive and reasonable cost.

Proposals shall conform to all instructions, conditions, and requirements included in the RFP. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this RFP, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the RFP.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this RFP reside with the State Purchasing Bureau. The point of contact (POC) for the procurement is as follows:

Name: Teresa Fleming, Buyer
Agency: State Purchasing Bureau, 1526 K Street, Suite 130, Lincoln, NE 68508
Telephone: 402-471-6500
E-Mail: as.materielpurchasing@nebraska.gov

From the date the RFP is issued until the Intent to Award is issued, communication from the Bidder is limited to the POC listed above. After the Intent to Award is issued, the Bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this RFP. The POC will issue any clarifications or opinions regarding this RFP in writing. Only the buyer can modify the RFP, answer questions, render opinions, and only the SPB or awarding agency can award a contract. Bidders shall not have any communication with, or attempt to communicate or influence any evaluator involved in this RFP.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the RFP POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's proposal, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

ACTIVITY		DATE/TIME
1.	Release RFP	November 1, 2018
2.	Last day to submit written questions	November 14, 2018
3.	State responds to written questions through RFP "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html	November 19, 2018
4.	Proposal opening Location: State Purchasing Bureau 1526 K Street, Suite 130 Lincoln, NE 68508	December 5, 2018 2:00 PM Central Time
5.	Review for conformance to RFP requirements	December 5, 2018
6.	Evaluation period	December 6, 2018 – December 20, 2018
7.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	TBD
8.	Post "Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchasing.html	December 20, 2018
9.	Contract finalization period	December 20, 2018 through January 5, 2019
10.	Contract award	January 8, 2019
11.	Contractor start date	January 8, 2019
12.	Plan Start Date	July 1. 2019

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any RFP provision must be submitted in writing to the State Purchasing Bureau and clearly marked "RFP Number 5953 Z1; Life Insurance Plans Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should present, as questions, any assumptions upon which the Bidder's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

It is preferred that questions be sent via e-mail to as.materielpurchasing@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that Bidders submit questions using the following format.

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchasing.html per the Schedule of Events.

E. PRICES

Prices submitted on the cost proposal form, once accepted by the State, shall remain fixed for the initial period of the contract. Any request for a price increase subsequent to the initial period of the contract shall not exceed five percent (5%) of the price bid for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the State Purchasing Bureau a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

F. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)

Contractor must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the contract.

G. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject bids, withdraw an intent to award or award, or terminate a contract if a bidder commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the bid, or prejudice the State.

The Bidder shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Bidder shall have an affirmative duty to report any violations of this clause by the Bidder throughout the bidding process, and throughout the term of this contract for the successful Bidder and their subcontractors.

H. DEVIATIONS FROM THE REQUEST FOR PROPOSAL

The requirements contained in the RFP become a part of the terms and conditions of the contract resulting from this RFP. Any deviations from the RFP in Sections II through VI must be clearly defined by the bidder in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the RFP, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this RFP, means any proposed changes or alterations to either the contractual language or

deliverables within the scope of this RFP. The State discourages deviations and reserves the right to reject proposed deviations.

I. SUBMISSION OF PROPOSALS

Bidders should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. The Bidder is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Bidder Contact Sheet". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or bidder's bid response packet. If a recipient phone number is required for delivery purposes, 402-471-6500 should be used. The RFP number should be included in all correspondence.

Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to requirements, completeness, and clarity of content. If the bidder's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

By signing the "Request for Proposal for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP.

The State shall not incur any liability for any costs incurred by bidders in replying to this RFP, in the demonstrations and/or oral presentations; or in any other activity related to bidding on this RFP.

The Technical and Cost Proposals Template should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

J. BID PREPARATION COSTS

The State shall not incur any liability for any costs incurred by Bidders in replying to this RFP, including any activity related to bidding on this RFP.

K. FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL

Violation of the terms and conditions contained in this RFP or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Termination of the resulting contract;
5. Legal action; and
6. Suspension of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

L. BID CORRECTIONS

A bidder may correct a mistake in a bid prior to the time of opening by giving written notice to the State of intent to withdraw the bid for modification or to withdraw the bid completely. Changes in a bid after opening are acceptable only if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

M. LATE PROPOSALS

Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the bidder and at bidder's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

N. PROPOSAL OPENING

The opening of proposals will be public and the bidders will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Vendors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

O. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Corporate Overview;
4. Completed Sections II through VI;
5. Completed Technical Approach (Attachment A: Contractor Requirements Matrix); and
6. Completed State Cost Proposal Template.

P. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this RFP may result in the rejection of this proposal and further administrative actions.

Q. EVALUATION OF PROPOSALS

All proposals that are responsive to the RFP will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
   a. the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the RFP;
   b. the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
   c. whether the bidder can perform the contract within the specified time frame;
   d. the quality of bidder performance on prior contracts;
   e. such other information that may be secured and that has a bearing on the decision to award the contract;
2. Technical Approach (Attachment A: Contractor Requirements Matrix); and,
3. Cost Proposal.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the RFP cover page under "Bidder must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Evaluation criteria weighting will be released with the RFP.

R. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the bidders to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Bidders' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

S. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the bidder, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring bidder. However, a bidder should provide its best offer in its original proposal. Bidders should not expect that the State will request a best and final offer.

T. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this RFP, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a contract.

U. AWARD

The State reserves the right to evaluate proposals and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the RFP process, the State of Nebraska may take one or more of the following actions:

1. Amend the RFP;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's RFP process and in bidder proposals that are not material, do not compromise the RFP process or a bidder's proposal, and do not improve a bidder's competitive position;
4. Accept or reject a portion of or all of a proposal;
5. Accept or reject all proposals;
6. Withdraw the RFP;
7. Elect to rebid the RFP;
8. Award single lines or multiple lines to one or more bidders; or,
9. Award one or more all-inclusive contracts.

The RFP does not commit the State to award a contract. Once intent to award decision has been determined, it will be posted to the Internet at: http://das.nebraska.gov/materiel/purchasing.html

Grievance and protest procedure is available on the Internet at: http://das.nebraska.gov/materiel/purchasing.html

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet.

II. TERMS AND CONDITIONS

Bidders should complete Sections II through VI as part of their proposal. Bidder is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The bidder should also provide an explanation of why the bidder rejected the clause or rejected the clause and provided alternate language. By signing the RFP, bidder is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this RFP. The State of Nebraska reserves the right to reject proposals that attempt to substitute the bidder's commercial contracts and/or documents for this RFP.

The bidders should submit with their proposal any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the bidder's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
SKS			•Conversion is not available for AD&D.

The contract resulting from this RFP shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the RFP;
3. Questions and Answers;
4. Contractor's proposal (RFP and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable ; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to RFP and any Questions and Answers, 4) the original RFP document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

C. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

D. BEGINNING OF WORK

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

E. CHANGE ORDERS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
			

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the RFP. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State

shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

F. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

G. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

H. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

I. **SEVERABILITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CK			

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

J. **INDEMNIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			Please reference Addendum page 11, section SS 1, paragraph 2.

1. **GENERAL**

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. **INTELLECTUAL PROPERTY**

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

K. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			Please reference Addendum page 6, section T.

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if order by the court, including attorney's fees and costs, if the other Party prevails.

L. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

M. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

N. **FORCE MAJEURE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			Please reference Addendum page 8, section DD.

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or man-made event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

O. **CONFIDENTIALITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			Please reference Addendum page 10, section MM.

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

P. **EARLY TERMINATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.
2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.
3. The State may terminate the contract immediately for the following reasons:
   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;

c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
g. Contractor intentionally discloses confidential information;
h. Contractor has or announces it will discontinue support of the deliverable; and,
i. In the event funding is no longer available.

Q. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CK			

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law; and
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees.
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the bidder's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html

   The completed United States Attestation Form should be submitted with the RFP response.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for services to be covered by any contract resulting from this RFP.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CK			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) year of termination or expiration of the contract, the contractor shall obtain an extended discovery

or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and one (1) year following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**

   The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

   The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

   The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$1,000,000 per occurrence / $2,000,000 aggregate
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
Independent Contractors	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$3,000,000 per occurrence
PROFESSIONAL LIABILITY	
Professional liability (Medical Malpractice)	Limits consistent with Nebraska Medical Malpractice Cap
Qualification Under Nebraska Excess Fund	
All Other Professional Liability (Errors & Omissions)	$10,000,000 Per Claim / $20,000,000 Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$2,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$2,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

If the mandatory COI subrogation waiver language or mandatory COI liability waiver language on the COI states that the waiver is subject to, condition upon, or otherwise limit by the insurance policy, a copy of the relevant sections of the policy must be submitted with the COI so the State can review the limitations imposed by the insurance policy.

3. **EVIDENCE OF COVERAGE**

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Administrative Services
Employee Wellness and Benefits
Attn: Contract Manager
1526 K Street, Suite 110
Lincoln, NE 68508

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

H. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

I. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

By submitting a proposal, bidder certifies that there does not now exist a relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this RFP or project. The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or an appearance of conflict of interest. The bidder certifies that it will not knowingly employ any individual known by bidder to have a conflict of interest.

The Parties shall not knowingly, for a period of two years after execution of the contract, recruit or employ any employee or agent of the other Party who has worked on the RFP or project, or who had any influence on decisions affecting the RFP or project.

J. SITE RULES AND REGULATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility

and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Contractor.

K. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

L. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at http://nitc.nebraska.gov/standards/2-201.html and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

M. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under the specifications in the contract in the event of a disaster.

N. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CR			

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor.

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Invoices should be sent to Department of Administrative Services, Employee Wellness and Benefits, 1526 K Street, Suite 110, Lincoln, NE 68508.

The invoice must contain the State's Account number and or ID number and the Coverage Period being billed. The invoice must list each plan and rates for the plans. Premiums are deducted via payroll on a Bi-Weekly and/or Monthly basis. After the close of business each month the total premiums deducted are paid to the Contractor via ACH payment. Premiums are not paid in advance. Example, August premiums would not be paid to the Contractor until after close of business on August 31st. In the example above, the 45 days starts on September 1st. As premiums are sent via ACH an Excel or PDF Report will be generated and provided to the Contractor by the State as backup documentation for the premiums paid. The report is produced manually and date of completion may vary from month to month.

The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

State will render payment to Contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the Contractor as solely determined by the State. (Neb. Rev. Stat. Section 73-506(1)) Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within RFP Response (Initial)	NOTES/COMMENTS:
CL			

The State shall have the right to audit the Contractor's performance of this contract upon a 30 days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor

will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

The State of Nebraska ("the State"), through Administrative Services, provides State employees access to life insurance. The State is seeking proposals from qualified life insurance companies to provide a fully-insured Life Insurance Plans for the State of Nebraska employees for approximately 16,125 eligible state employees effective on July 1, 2019. The State is committed to offering a life insurance program which promotes cost-effective services. The current provider is Aetna under Contract 55660 O4.

The State's objectives are:

1. Minimize the cost and rate of future rate increases.
2. Improve employee satisfaction with the life insurance program.
3. Establish performance targets to assess and monitor carrier's performance.
4. Provide portability and conversion provisions to employees.

B. PROJECT ENVIRONMENT

The State provides eligible permanent full-time employees with a basic life insurance benefit of $20,000 at no cost to the employee and to eligible permanent part-time employees for a minimal monthly charge. It is mandatory for all full-time employees to enroll for the $20,000 basic life insurance. Part-time employees have the option to choose to enroll in the coverage.

At the employees' expense, the State makes Supplemental Life Insurance (Employee), Supplemental Life Insurance (Dependent) and Accidental Death and Dismemberment (AD&D) insurance available to all eligible permanent and part-time employees.

Employees currently may purchase supplemental life in the amount of .5x, 1x, 1.5x, 2x, 3x, 4x and 5x their annual salary.

Eligible employees may elect supplemental life insurance for their spouse and dependent child(ren) up to age 26. The plan must offer two dependent life options to choose from and both include coverage for spouse and or child(ren). Eligible employees must be enrolled in Basic Life to elect Supplemental Life and AD&D insurance.

Currently a Waiver of Premium is in place. Contractor must provide a conversion option available for any employee that leaves employment and wants to take their current coverage with them. The employee will be responsible for the cost. (The cost will not be related to group coverage with the State.)

Employees who have been approved for the life waiver of premium prior to the effective date of July 1, 2019, will remain the liability of the current life insurance company.

The current insurance plan includes coverage for three State of Nebraska employee groups: Active Nebraska Department of Labor (NDOL) employees employed prior to July 1, 1991; Retired NDOL employees; and all other Eligible Permanent Employees with the State of Nebraska. Group life benefits vary by these groups as described in Attachment B: Plan Structure – Basic and Supplemental.

The Contractor must offer the exact same current plan to the NDOL employees due to NDOL employees being grandfathered into the Plan. There will not be any new enrollees added to this group.

Of the State's approximately **16,125** eligible permanent employees, approximately **15,158** are enrolled in the current basic life plan. The State maintains the same life insurance plans for employees under the labor contract as it does for those who are not covered under the labor contract. The premium contribution for Supplemental Life Insurance (Employee), Supplemental Life Insurance (Dependent) and Accidental Death and Dismemberment (AD&D) insurance is 100% by the employee.

A census with the current participation in both basic and supplemental life is available in Attachment C: Census Report. The current rates have been in effect since July 1, 2013. The Current Rate Structure – Supplemental Life, Dependent Life and AD&D can be found in Attachment D: Current Rates. Claim Experience and Premium History can be found in Attachment E.

C. CONTRACTOR REQUIREMENTS

Bidder to complete Attachment A: Contractor Requirements Matrix

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. REQUEST FOR PROPOSAL FORM

By signing the "RFP for Contractual Services" form, the bidder guarantees compliance with the provisions stated in this RFP, agrees to the Terms and Conditions stated in this RFP unless otherwise agreed to, and certifies bidder maintains a drug free work place environment.

The RFP for Contractual Services form must be signed using an indelible method (not electronically) and returned per the schedule of events in order to be considered for an award.

Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted. No electronic, e-mail, fax, voice, or telephone proposals will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchasing.html

Further, Sections II through VII must be completed and returned with the proposal response.

2. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the bidder should describe the circumstances of such change

and indicate when the change will likely occur. Any change of ownership to an awarded vendor(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's proposal response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's proposal response is or was an employee of the State within the past two (2) years, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a Subcontractor to the bidder, as of the due date for proposal submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed Subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's proposal accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this RFP in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the proposal.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this RFP. These descriptions should include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a bidder performed as the prime Contractor, the description should provide the originally scheduled completion

date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. **SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH**
The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this RFP. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the RFP in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. **SUBCONTRACTORS**
If the bidder intends to Subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the Subcontractor(s);
ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

3. **TECHNICAL APPROACH**
The technical approach section of the Technical Proposal should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Technical considerations;
d. Detailed project work plan; and
e. Deliverables and due dates.

VII. COST PROPOSAL REQUIREMENTS

This section describes the requirements to be addressed by bidders in preparing the State's Cost Sheet. The bidder must use the State's Cost Sheet. The bidder should submit the State's Cost Sheet in accordance with Section I Submission of Proposal.

THE STATE'S COST SHEET AND ANY OTHER COST DOCUMENT SUBMITTED WITH THE PROPOSAL SHALL NOT BE CONSIDERED CONFIDENTIAL OR PROPRIETARY AND IS CONSIDERED A PUBLIC RECORD IN THE STATE OF NEBRASKA AND WILL BE POSTED TO A PUBLIC WEBSITE.

A. COST SHEET

This summary shall present the total fixed price to perform all of the requirements of the RFP. The bidder must include details in the State's Cost Sheet supporting any and all costs.

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

B. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the RFP. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Corporate Overview

a.	Bidder Identification and Information	
	Company Name:	**United of Omaha Life Insurance Company**
	Address:	Mutua of Omaha Plaza, Omaha, NE 68175
	Entity Organization:	Subsidiary of Mutual of Omaha Insurance Company
	State Organized to do Business:	28 group offices located thrughout the United States
	Name and Form Change (since first organized)	Mutual of Omaha entered in the insurance marketplace in 1909 and started selling life insurance in 1926. We have sold and service group insurance for over 90 years. United of Omaha underwrites life coverages in all states except New York. Companion Life Insurance Company; Rye, NY underwrites life coverages in New York. Under Articles of Incorporation filed March 5, 1909 with Nebraska Insurance Department, Mutual was license as a mutual assessment plan and commenced business under the name "Mutual Benefit Health & Accident Association". Charter amendments adopted February 10, 1962, changed the corporate structure to a mutual legal reserve basis and provided for the adoption fo the present company name, "Mutual of Omaha Insurance Company". United of Omaha Life Insurance Company is wholly-owned subsidiary of Mutual of Omaha Insurance Company.
	Federal Employer Indentification Number:	47-0246511
b.	Financial Statements	Please refer to the Exhibit Section for Financial Statements
c.	Change of Ownership	Mutual of Omaha does not anticipate any change in ownership or control of the company during the next 12 months.
d.	Office Location	Mutual of Omaha, Omaha Group Office, 11605 Miracle Hills Drive Suite 101, Omaha, NE 68154
e.	Relationships with the State	Mutual of Omaha currently underwrites the State of Nebraska's Voluntary Long-Term Disability programs (G00091L8)
f.	Bidder Employee Relationship to State	No individual named in this proposal response has been an employee of the State of Nebraska with the past 12 months.
g.	Contract Performance	Groups terminate their coverage with Mutual of Omaha for many reasons which can range from rates to performance issues, but as our persistancy rates indicates, over 90% of our customers choose to stay with Mutual of Omaha.
h.	Summary of Bidder's Corporate Experience	Our references can be found under the reference section of the Technical Proposal.
i.	Summary of Bidder's Proposed Personnel/Management Approacth	The Client Account Specialist assigned to the State of Nebraska account would be Ryan Klaus. He will be the primary person responsible for the day to day service for this account. He resume can be found in the Exhibit section.
j.	Subcontractors	Not Applicable

Attachment A
Contractor Requirements Matrix
Request for Proposal Number 5953 Z1

Bidder Name: Mutual of Omaha

Bidders should provide a response to each of the following Contractor requirements below.

	CONTRACT ADMINISTRATION
1.	Contractor must include a Waiver of Premium provision for employees becoming disabled on or after the program effective date of July 1, 2019.
	Response: Confirmed
2.	Provide the Schedule of Life Insurance Benefits including all options (.5x, 1x, 1.5x, 2x, 3x, 4x and 5x annual salary) and the Basic and Supplemental Aggregate Maximum and Minimum coverage. State if you allow exceptions in excess of the maximum amount of 5x. Example: An employee may elect 5x their salary which exceeds the maximum coverage.
	Response: The State currently has a $2,000,000 maximum for Basic and Supplemental Life combined. We are separating the maximum as we did when we were the prior carrier from 1/1/2004 to 7/1/2013. Employees will have a $20,000 Basic Life maximum and $1,980,000 Supplemental Life maximum for a total maximum of $2,000,000.Our life reinsurer has approved the Supplemental Life maximum of the lessor of 5 x's salary or $1,960,000. We will not be allowing elections in excess of 5 x's salary rounded up to the next $1,000 or $1,980,000. The highest current employee election is $950,000.
3.	Provide coverage on a discontinuance and replacement basis (no loss, no gain) for eligible employees participating in the current plans on the effective date of the new coverage.
	Response: We do not waive the actively at work requirement in our policies. Employees who are not actively at work should apply for life conversion. Our policies do contain a continuity of coverage provision. It allows employees who are not actively at work and who are not totally disabled, but who are injured, sick, or on a protected leave of absence to be covered under our policy at the time of takeover if certain conditions are met. This provision is not a "no loss, no gain" provision.
4.	Adhere to the inclusion of provisions to protect the State from multiple deaths in a single occurrence.
	Response: Claims will be paid accordingly to the Contract.
5.	Refrain from issuing any external communications material that mentions the State's benefit plans without written approval from the State. This includes newsletters and publications to agents, brokers and consultants.
	Response: Confirmed
6.	Provide ongoing assistance in administration, claim adjudication, and general problem solving. Periodic account servicing meetings will be held with the account manager and claims support group.
	Response: Confirmed
7.	Accept the current enrollment files and beneficiary designations for the State's employees.
	Response: Confirmed
8.	Describe proof of loss required before a life or AD&D claim is filed.
	Response: When a death claim is received, the analyst will complete a review of eligibility. This will include review of the cause and manner of death as well as verifying the beneficiary designation. For AD&D, we would require a completed claim form along with a police/accident report if applicable, a toxicology report.

9.	Maintain an internal audit program and provide the State with a copy of the most recent internal audit report upon request.
	Response: We have our own internal audit process as well as regular state audits that are performed on life claims.
10.	Review all plans, draft plan abstracts, and confirm plan provisions with the State.
	Response: Confirmed
11.	Draft, revise, and finalize the policy and benefit summaries (Summary Plan Descriptions (SPB)/booklets) for review by the State before February 12 of each calendar year.
	Response: Confirmed
12.	Provide SPDs in an electronic format for access via internet or intranet.
	Response: Confirmed
13.	Provide one claim office with a dedicated unit and an assigned account executive to assist the State in the ongoing administration of the program.
	Response: Confirmed
14.	Design, submit for approval, and print enrollment forms with the State's logo for use by plan participants to enroll, designate beneficiaries, and change their coverages, in accordance with plan provisions.
	Response: Confirmed
15.	When customized printing is requested by the State, present a complete draft and subsequent proof to the State for sign-off. The Contractor must ensure that logo placement and color requirements are met. Contractor will be responsible for costs of printing booklets, certificates, or SPDs as required.
	Response: Confirmed
16.	Provide routine underwriting and actuarial services.
	Response: Confirmed
17.	Deliver an Administration Manual containing all user guidelines on such matters as eligibility, reports, plan summaries and procedures 60 days prior to plan year.
	Response: Confirmed
18.	Offer web-based enrollment and termination.
	Response: Confirmed

19.	Communications (phone calls, emails) should be responded to within 24 hours. Describe your customer service process, including the hours of operation and methods of contact.
	Response: We can provide dedicated customer service managers, client specific claim examiners, dedicated claim consultant and implementation manager. Service Team hours are 7:00 AM to 7:00 PM, CST, Monday through Friday.
20.	Maintain claim files to support payment, denials and appeals. Documentation must be legally acceptable and readily accessible.
	Response: Confirmed
21.	Indicate settlement processes and options available to beneficiaries. Specify the interest credit on claims from the date of death or proof of death until payment to beneficiary.
	Response: Lump sum payment is the standard claim payment. We pay interest on Life Claims according to state statutes.
22.	Make determinations with respect to submitted claims, including claim investigation and analysis prior to payment.
	Response: When a death claim is received, the analyst will complete a review of eligibility. This will include review of the cause and manner of death as well as verifying the beneficiary designation.
23.	100% of life claims will be processed within 15 business days of the receipt of required documentation.
	Response: Our time service standard for processing life claims is 90% within 8 business days.
24.	Contractor must have a process for finding missing beneficiaries.
	Response: We will make attempts at contacting the beneficiary using the information on the beneficiary form or any information provided by the Policyholder. We may also utilize the services of our Special Investigations area. If the beneficiary is still living, but cannot be located, the benefit will be placed in abandoned property.
25.	Provide the exact same current plan to the NDOL employees due to NDOL employees being grandfathered into the Plan.
	Response: Confirmed
	IMPLEMENTATION
26.	Provide a detailed timeline and implementation plan including deadlines set forth in this RFP including State resources and personnel required.
	Response: Confirmed
27.	Load, audit and insure clean eligibility data a minimum of 30 days prior to program effective date of July 1, 2019.
	Response: Confirmed

28.	Identify any programs, systems, or administrative opportunities that your organization can provide during the implementation process that would be beneficial to the State.
	Response: A dedicated Implementation Manager will available for the installation of the State of Nebraska in a timely and accurate manner. Please reference the Implementation Work Plan tab seciton.
29.	Attach a description of your conversion process and include a copy of your conversion request form, if applicable.
	Response: Upon termination of coverage, an employee who terminates may, within 31 days of the termination, covert to a whole life policy by completing a conversion application. The amount converted may not exceed the face amount inforce at time of termination. Rates are determined by the age and sex of the applicant at the time of the conversion application.
	REPORTING
30.	Monthly and quarterly claims paid/denied reports must be available no later than the end of the month following the close of the period in question.
	Response: Confirmed
31.	A year-end financial accounting for the program within 60 days of the contract anniversary date.
	Response: Confirmed
32.	Annual generation of eligibility listing in hard copy or online reporting. Describe your online reporting function(s).
	Response: Online reports are available but not in real time. Claims data for reporting purposes is updated overnight. These reports provide access to pertinent policyholder and claim information with the ability to enter specific report parameters.
	PERFORMANCE GUARANTEES
33.	Do you have a formal performance guarantee program? If so, please provide a copy.
	Response: Yes, please reference the Exhibit Tab section.
	BILLING
34.	Attach a description of premium billing procedures. Include information on the timing of billing, billing-payment reconciliations, and ability to provide for client self-billing.
	Response: Clients have two choices for premium billing administration (list billed or self billed). If list billed,the Policyholder will receive a detailed invoice reflecting specific coverages and amounts by enrolled employee. Mutual of Omaha will prepare billing statements with a complete accounting of all current payments and charges, as well as prior credits. The Policyholder will then mail the Premium Remittance Slip along with the premium payment to ensure accurate allocation of premiums. If self billed, the Policyholder is responsible for keeping detailed enrollment records, which are only reported to Mutual of Omaha upon renewal or by request; a signed enrollment form also must be submitted with any claim form. Mutual of Omaha will provide a blank Billing Detail Form to assist in providing a comprehensive number of covered lives, volume and premium. Premium submission is the same as list bill, however, the billing detail must also be provided (either online, via fax or email) at same time as payment. Online bill pay is also available through Employer Access for both self and list billed groups. All premium payments are due and payable on or before the due date as provided in the master contract. After the first premium has been paid, a standard grace period of 31 days from each premium due date shall be granted for the payment of premium. The premium payable for each period of coverage is the sum of the individual premiums for each insured person, including any dependents' premiums. Individual premiums are based on an insured person's classification when a period of coverage begins.

ADDENDUM ONE to Contract Award
Terms and Conditions
RFP 4203 Z1 Long Term Disability for the State of Nebraska
Between
The State of Nebraska and United of Omaha Life Insurance Company

The following Terms and Conditions, Addendum One of Contract 55674 O4 have been reviewed and agreed upon between United of Omaha Life Insurance Company "Contractor" and the State of Nebraska "State". This addendum will become part of the contract for Long Term Disability for the State of Nebraska. The terms and conditions of this Addendum shall supersede, prevail and govern in the case of any inconsistencies with the Terms and Conditions indicated in Section III of the Request for Proposal, except that any section herein marked "Reserved" shall have no effect on the Terms and Conditions indicated in Section III of the Request for Proposal.

By signing this Addendum the Contractor guarantees compliance with the provisions stated herein, agrees to the terms and conditions and certifies Contractor maintains a drug free work place environment.

A. GENERAL

The contract resulting from this Request for Proposal shall only incorporate the following documents:

1. Amendment to Contract Award with the most recent dated amendment having the highest priority;
2. Contract Award, Group Voluntary Long Term Disability Insurance Policy # G00091L8 and any attached Addenda;
3. The signed Request for Proposal form and the Contractor's Proposal;
4. Amendments to RFP and any Questions and Answers;
5. The original RFP document and any addenda.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to Contract Award with the most recent dated amendment having the highest priority, 2) Contract Award, Group Voluntary Long Term Disability Insurance Policy # G00091L8 and any attached Addenda, 3) The signed Request for Proposal form and the Contractor's Proposal, 4) Amendments to RFP and any Questions and Answers, 5) The original RFP document and any addenda.

Any ambiguity in any provision of this contract which shall be discovered after its execution shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. RESERVED

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION

The contractor shall comply with all applicable local, State and Federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment

Practice Act prohibits contractors of the State of Nebraska, and their subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions or privileges of employment because of race, color, religion, sex, disability, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The contractor shall insert a similar provision in all subcontracts for services to be covered by any contract resulting from this Request for Proposal.

D. PERMITS, REGULATIONS, LAWS

The contractor shall procure and pay for all permits, licenses and approvals necessary for the execution of the contract. The contractor shall comply with all applicable local, state, and federal laws, ordinances, rules, orders and regulations.

E. OWNERSHIP OF INFORMATION AND DATA

The State of Nebraska shall have the unlimited right to publish, duplicate, use and disclose all information and data developed or derived by the contractor pursuant to this contract subject to applicable State and Federal laws, regulations and the terms of Sections MM and NN herein.

The contractor must guarantee that it has the full legal right to the materials, supplies, equipment, and other rights or titles (e.g. rights to licenses transfer or assign deliverables) necessary to execute this contract. The contract price shall, without exception, include compensation for all royalties and costs arising from patents, trademarks and copyrights that are in any way involved in the contract. It shall be the responsibility of the contractor to pay for all royalties and costs, and the State must be held harmless from any such claims.

F. INSURANCE REQUIREMENTS

The contractor shall not commence work under this contract until he or she has obtained all the insurance required hereunder and such insurance has been approved by the State. If contractor will be utilizing any subcontractors, the contractor is responsible for obtaining the certificate(s) of insurance required herein under from any and all subcontractor(s). Contractor is also responsible for ensuring subcontractor(s) maintain the insurance required until completion of the contract requirements. The contractor shall not allow any subcontractor to commence work on his or her subcontract until all similar insurance required of the subcontractor has been obtained and approved by the contractor. Approval of the insurance by the State shall not limit, relieve or decrease the liability of the contractor hereunder.

If by the terms of any insurance a mandatory deductible is required, or if the contractor elects to increase the mandatory deductible amount, the contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

1. WORKERS' COMPENSATION INSURANCE

The contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the contractor shall require the subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. This policy shall include a waiver of subrogation in favor of the State. The amounts of such insurance shall not be less than the limits stated hereinafter.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance

as shall protect contractor and any subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the contractor or by any subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury and Contractual Liability coverage. The policy shall include the State, and others as required by the Contract Documents, as an Additional Insured. This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered excess and non-contributory. The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned and Hired vehicles.

3. INSURANCE COVERAGE AMOUNTS REQUIRED

a. WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY

Coverage A	Statutory
Coverage B	
Bodily Injury by Accident	$100,000 each accident
Bodily Injury by Disease	$500,000 policy limit
Bodily Injury by Disease	$100,000 each employee

b. COMMERCIAL GENERAL LIABILITY

General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 any one person
Bodily Injury/Property Damage	$1,000,000 per occurrence
Fire Damage	$50,000 any one fire
Medical Payments	$5,000 any one person

c. COMMERCIAL AUTOMOBILE LIABILITY

Bodily Injury/Property Damage	$1,000,000 combined single limit

d. UMBRELLA/EXCESS LIABILITY

Over Primary Insurance	$1,000,000 per occurrence

4. EVIDENCE OF COVERAGE

The contractor should furnish the State, with their proposal response, a certificate of insurance coverage complying with the above requirements to the attention of the Buyer, Administrative Services, State Purchasing Bureau, 301 Centennial Mall S, 1st Fl, Lincoln, NE 68508 (facsimile 402-471-2089). These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration and amounts and types of coverage afforded. If the State is damaged by the failure of the contractor to maintain such insurance, then the contractor shall be responsible for all reasonable costs properly attributable thereto.

Notice of cancellation of any required insurance policy must be submitted to Administrative Services State Purchasing Bureau when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

G. COOPERATION WITH OTHER CONTRACTORS

The State may already have in place or choose to award supplemental contracts for work related to this Request for Proposal, or any portion thereof.

1. The State reserves the right to award the contract jointly between two or more potential contractors, if such an arrangement is in the best interest of the State.
2. The contractor shall agree to cooperate with such other contractors, and shall not commit or permit any act which may interfere with the performance of work by any other contractor.

H. INDEPENDENT CONTRACTOR

It is agreed that nothing contained herein is intended or should be construed in any manner as creating or establishing the relationship of partners between the parties hereto. The contractor represents that it has, or will secure at its own expense, all personnel required to perform the services under the contract. The contractor's employees and other persons engaged in work or services required by the contractor under the contract shall have no contractual relationship with the State; they shall not be considered employees of the State.

All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination against the contractor, its officers or its agents) shall in no way be the responsibility of the State. The contractor will hold the State harmless from any and all such claims. Such personnel or other persons shall not require nor be entitled to any compensation, rights or benefits from the State including without limit, tenure rights, medical and hospital care, sick and vacation leave, severance pay or retirement benefits.

I. CONTRACTOR RESPONSIBILITY

The contractor is solely responsible for fulfilling the contract, with responsibility for all services offered and products to be delivered as stated in the Request for Proposal, the contractor's proposal, and the resulting contract. The contractor shall be the sole point of contact regarding all contractual matters.

If the contractor intends to utilize any subcontractors' services, the subcontractors' level of effort, tasks and time allocation must be clearly defined in the contractor's proposal. The contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal, in the performance of the contract, without the prior written authorization of the State. Following execution of the contract, the contractor shall proceed diligently with all services and shall perform such services with qualified personnel in accordance with the contract.

J. CONTRACTOR PERSONNEL

The contractor warrants that all persons assigned to the project shall be employees of the contractor or specified subcontractors, and shall be fully qualified to perform the work required herein. Personnel employed by the contractor to fulfill the terms of the contract shall remain under the sole direction and control of the contractor. The contractor shall include a similar provision in any contract with any subcontractor selected to perform work on the project. Notwithstanding the foregoing, the parties acknowledge that individuals performing services on behalf of contractor are employed by Mutual of Omaha Insurance Company, which wholly owns contractor. The activities of contractor in performing services under the contract shall be performed by employees of Mutual of Omaha acting on behalf of and as agents of contractor and shall remain under the sole direction and control of the contractor.

Personnel commitments made in the contractor's proposal shall not be changed without the prior written approval of the State. Replacement of key personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

The State reserves the right to require the contractor to reassign or remove from the project any contractor or subcontractor employee.

In respect to its employees, the contractor agrees to be responsible for the following:

1. any and all employment taxes and/or other payroll withholding;
2. any and all vehicles used by the contractor's employees, including all insurance required by state law;
3. damages incurred by contractor's employees within the scope of their duties under the contract;
4. maintaining workers' compensation and health insurance and submitting any reports on such insurance to the extent required by governing State law; and
5. determining the hours to be worked and the duties to be performed by the contractor's employees.

Notice of cancellation of any required insurance policy must be submitted to the State when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

K. STATE OF NEBRASKA PERSONNEL RECRUITMENT PROHIBITION

The contractor shall not, at any time, recruit or employ any State employee or agent who has worked on the Request for Proposal or project, or who had any influence on decisions affecting the Request for Proposal or project.

L. CONFLICT OF INTEREST

By submitting a proposal, bidder certifies that there does not now exist any relationship between the bidder and any person or entity which is or gives the appearance of a conflict of interest related to this Request for Proposal or project.

The bidder certifies that it shall not take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder or which creates an actual or appearance of conflict of interest.

The bidder certifies that it will not employ any individual known by bidder to have a conflict of interest.

M. RESERVED

N. ERRORS AND OMISSIONS

The bidder shall not take advantage of any errors and/or omissions in this Request for Proposal or resulting contract. The bidder must promptly notify the State of any errors and/or omissions that are discovered.

O. BEGINNING OF WORK

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful contractor. The contractor will be notified in writing when work may begin.

P. ASSIGNMENT BY THE STATE

The State shall have the right to assign or transfer the contract or any of its interests herein to any agency, board, commission, or political subdivision of the State of Nebraska. There shall be no charge to the State for any assignment hereunder.

Q. ASSIGNMENT BY THE CONTRACTOR

The contractor may not assign, voluntarily or involuntarily, the contract or any of its rights or obligations hereunder (including without limitation rights and duties of performance) to any third party, without the prior written consent of the State, which will not be unreasonably withheld.

R. RESERVED

S. GOVERNING LAW

The contract shall be governed in all respects by the laws and statutes of the State of Nebraska. Any legal proceedings against the State of Nebraska regarding this Request for Proposal or any resultant contract shall be brought in the State of Nebraska administrative or judicial forums as defined by State law. The contractor must be in compliance with all Nebraska statutory and regulatory law.

T. ATTORNEY'S FEES

In the event of any litigation, appeal or other legal action to enforce any provision of the contract, the contractor agrees to pay all expenses of such action, as permitted by law, including reasonable attorney's fees and costs, if the State is the prevailing party.

U. ADVERTISING

The contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its services are endorsed or preferred by the State. News releases pertaining to the project shall not be issued without prior written approval from the State.

V. STATE PROPERTY

The contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the contractor's use during the performance of the contract. The contractor shall reimburse the State for any loss or damage of such property, normal wear and tear is expected.

W. SITE RULES AND REGULATIONS

The contractor shall use its best efforts to ensure that its employees, agents and subcontractors comply with site rules and regulations while on State premises. If the contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to between the State and the contractor.

X. NOTIFICATION

During the bid process, all communication between the State and a bidder shall be between the bidder's representative clearly noted in its proposal and the buyer noted in Section II, A. Procuring Office and Contact Person of this RFP. After the award of the contract, all notices under the contract shall be deemed duly given upon delivery to the staff designated as the point of contact for this Request for Proposal, in person, or upon delivery by U.S. Mail, facsimile, or e-mail. Each bidder should provide in its proposal the name, title and complete address of its designee to receive notices.

1. Except as otherwise expressly specified herein, all notices, requests or other communications shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth above, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or three (3) days following deposit in the mail.

2. Whenever the contractor encounters any difficulty which is delaying or threatens to delay its timely performance under the contract, the contractor shall immediately give notice thereof in writing to the State reciting all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the State of any of its rights or remedies to which it is entitled by law or equity or pursuant to the provisions of the contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

For the duration of the contract, all communication between contractor and the State regarding the contract shall take place between the contractor and individuals specified by the State in writing. Communication about the contract between contractor and individuals not designated as points of contact by the State is strictly forbidden.

Y. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon 30 days written notice to the contractor. Such termination shall not relieve the contractor of warranty or other service obligations incurred under the terms of the contract. In the event of cancellation the contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the contractor or of any substantial part of the contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its contractor, its employees, officers, directors or shareholders;
   e. an involuntary proceeding has been commenced by any party against the contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) days; or (ii) the contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the contractor under any of the chapters of Title 11 of the United States Code;
   g. contractor intentionally discloses confidential information;
   h. contractor has or announces it will discontinue support of the deliverable;
   i. second or subsequent documented "vendor performance report" form deemed acceptable by the State Purchasing Bureau.

Z. FUNDING OUT CLAUSE OR LOSS OF APPROPRIATIONS

The State may terminate the contract, in whole or in part, in the event funding is no longer available. The State's obligation to pay amounts due for fiscal years following the current fiscal

year is contingent upon legislative appropriation of funds for the contract. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal years for which such funds are not appropriated. The State will give the contractor written notice thirty (30) days prior to the effective date of any termination, and advise the contractor of the location (address and room number) of any related equipment. All obligations of the State to make payments after the termination date will cease and all interest of the State in any related equipment will terminate. The contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the contractor be paid for a loss of anticipated profit.

AA. BREACH BY CONTRACTOR

The State may terminate the contract, in whole or in part, if the contractor fails to perform its obligations under the contract in a timely and proper manner. The State may, by providing a written notice of default to the contractor, allow the contractor to cure a failure or breach of contract within a period of thirty (30) days (or longer at State's discretion considering the gravity and nature of the default). Said notice shall be delivered by Certified Mail, Return Receipt Requested or in person with proof of delivery. Allowing the contractor time to cure a failure or breach of contract does not waive the State's right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the contractor, the State may contract the service from other sources and hold the contractor responsible for any excess cost occasioned thereby.

BB. ASSURANCES BEFORE BREACH

If any document or deliverable required pursuant to the contract does not fulfill the requirements of the Request for Proposal/resulting contract, upon written notice from the State, the contractor shall deliver assurances in the form of additional contractor resources at no additional cost to the project in order to complete the deliverable, and to ensure that other project schedules will not be adversely affected.

CC. PENALTY

In the event that the contractor fails to perform any substantial obligation under the contract, the State may withhold all monies due and payable to the contractor, without penalty, until such failure is cured or otherwise adjudicated. Failure to meet the dates stipulated in the contract for the deliverables may result in an assessment of penalty due the State of $100.00 dollars per day, until the deliverables are approved. Contractor will be notified in writing when penalty will commence.

DD. FORCE MAJEURE

Neither party shall be liable for any costs or damages resulting from its inability to perform any of its obligations under the contract due to a natural disaster, or other similar event outside the control and not the fault of the affected party ("Force Majeure Event"). A Force Majeure Event shall not constitute a breach of the contract. The party so affected shall immediately give notice to the other party of the Force Majeure Event. The State may grant relief from performance of the contract if the contractor is prevented from performance by a Force Majeure Event. The burden of proof for the need for such relief shall rest upon the contractor. To obtain release based on a Force Majeure Event, the contractor shall file a written request for such relief with the State Purchasing Bureau. Labor disputes with the impacted party's own employees will not be considered a Force Majeure Event and will not suspend performance requirements under the contract.

EE. PROHIBITION AGAINST ADVANCE PAYMENT

Payments shall not be made until contractual deliverable(s) are received and accepted by the State.

FF. PAYMENT

State will render payment to contractor when the terms and conditions of the contract and specifications have been satisfactorily completed on the part of the contractor as solely determined by the State. Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408). The State may require the contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any services provided by the contractor prior to the Effective Date, and the contractor hereby waives any claim or cause of action for any such services.

GG. INVOICES

Invoices for payments must be submitted by the contractor to the agency requesting the services with sufficient detail to support payment. The terms and conditions included in the contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

HH. AUDIT REQUIREMENTS

All contractor books, records and documents relating to work performed or monies received under the contract shall be subject to audit at any reasonable time upon the provision of reasonable notice by the State, subject to applicable State and Federal laws. These records shall be maintained for a period of five (5) full years from the date of final payment, or until all issues related to an audit, litigation or other action are resolved, whichever is longer. All records shall be maintained in accordance with generally accepted accounting principles.

In addition to, and in no way in limitation of any obligation in the contract, the contractor shall agree that it will be held liable for any State audit exceptions, and shall return to the State all payments made under the contract for which an exception has been taken or which has been disallowed because of such an exception. The contractor agrees to correct immediately any material weakness or condition reported to the State in the course of an audit.

II. TAXES

The State is not required to pay taxes of any kind and assumes no such liability as a result of this solicitation. Any property tax payable on the contractor's equipment which may be installed in a state-owned facility is the responsibility of the contractor.

JJ. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the contractor or subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

KK. CHANGES IN SCOPE/CHANGE ORDERS

The State may, at any time with written notice to the contractor, make changes within the general scope of the contract. Changes in scope shall only be conducted with the written approval of the State's designee as so defined by the State from time to time. (The State retains the right to employ the services of a third party to perform any change order(s)).

The State may, at any time work is in progress, by written order, make alterations in the terms of work as shown in the specifications, require the performance of extra work, decrease the quantity of work, or make such other changes as the State may find necessary or desirable. The

contractor shall not claim forfeiture of contract by reasons of such changes by the State. Changes in work and the amount of compensation to be paid to the contractor for any extra work so ordered shall be determined in accordance with the applicable unit prices of the contractor's proposal.

Corrections of any deliverable services or performance of work required pursuant to the contract shall not be deemed a modification requiring a change order.

LL. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the particular provision held to be invalid.

MM. CONFIDENTIALITY

All materials and information provided by the State or acquired by the contractor on behalf of the State shall be regarded as confidential information. All materials and information provided by the State or acquired by the contractor on behalf of the State shall be handled in accordance with applicable Federal and State laws, regulations, and ethical standards. The contractor must ensure the confidentiality of such materials or information. Should said confidentiality be breached by a contractor; contractor shall notify the State immediately of said breach and take immediate corrective action. It is incumbent upon the contractor to inform its officers and employees of all applicable Federal and State laws and regulations.

Data contained in the contract and all documentation provided therein, become the property of the State of Nebraska and the data becomes public information. If the contractor wishes to have any information withheld from the public, such information must fall within the definition of proprietary information contained within Nebraska's public record statutes. All proprietary information the contractor wishes the State to withhold must be submitted in a sealed package. The separate package must be clearly marked PROPRIETARY on the outside of the package. Failure of the contractor to follow the instructions for submitting proprietary and copyrighted information may result in the information being viewed by other vendors and the public. Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, if contractor submits information as proprietary, it may be required to prove specific, named competitor(s) who would be advantaged by release of the information and the specific advantage the competitor(s) would receive. Although every effort will be made to withhold information that is properly submitted as proprietary and meets the State's definition of proprietary information, the State is under no obligation to maintain the confidentiality of proprietary information and accepts no liability for the release of such information.

NN. RESERVED

OO. RESERVED

PP. PRICES

All prices, costs, terms and conditions outlined in the proposal shall remain fixed and valid commencing on the opening date of the proposal until an award is made (and for bidder receiving award prices shall remain as bid for the duration of the contract unless otherwise so stated in the contract) or the Request for Proposal is cancelled.

Contractor represents and warrants that all prices for services, now or subsequently specified are as low as and no higher than prices which the contractor has charged or intends to charge customers other than the State for the same or similar products and services of the same or equivalent quantity and quality for delivery or performance during the same periods of time. If, during the term of the contract, the contractor shall reduce any and/or all prices charged to any customers other than the State for the same or similar products or services specified herein, the contractor shall make an equal or equivalent reduction in corresponding prices for said specified products or services.

Contractor also represents and warrants that all prices set forth in the contract and all prices in addition, which the contractor may charge under the terms of the contract, do not and will not violate any existing federal, state or municipal law or regulations concerning price discrimination and/or price fixing. Contractor agrees to hold the State harmless from any such violation. Prices quoted shall not be subject to increase throughout the contract period unless specifically allowed by these specifications.

QQ. RESERVED

RR. RESERVED

SS. INDEMNIFICATION

1. GENERAL

The contractor agrees to defend, indemnify, hold, and save harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs and expenses of every nature, including investigation costs and expenses, settlement costs, and reasonable attorneys' fees and expenses ("the claims"), sustained or asserted against the State, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the contractor, its employees, subcontractors, consultants, representatives, and agents, except to the extent such contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

The State shall, to the extent allowed under the Constitution and laws of the State of Nebraska, agrees to hold contractor harmless from liability resulting from the negligent acts or omissions of the State, its agents or employees pertaining to the activities to be carried out pursuant to the obligations of this Contract; provided, however, that the State shall not hold contractor harmless from claims arising out of the willful misconduct, negligence, error or omission of contractor, its officers, agents, or employees, or any person or entity not subject to State's supervision or control.

2. INTELLECTUAL PROPERTY

The contractor agrees it will at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the contractor or its employees, subcontractors, consultants, representatives, and agents; provided, however, the State gives the contractor prompt notice in writing of the claim. The contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the contractor has indemnified the State, the

contractor shall at the contractor's sole cost and expense promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the contractor, and the State may receive the remedies provided under this RFP.

3. **PERSONNEL**

The contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel provided by the contractor.

TT. NEBRASKA TECHNOLOGY ACCESS STANDARDS

Contractor shall review the Nebraska Technology Access Standards, found at http://www.nitc.nebraska.gov/standards/accessibility/accessibility_standards.pdf and ensure that products and/or services provided under the contract comply with the applicable standards. In the event such standards change during the contractor's performance, the State may create an amendment to the contract to request that contract comply with the changed standard at a cost mutually acceptable to the parties.

UU. ANTITRUST

The contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

VV. DISASTER RECOVERY/BACK UP PLAN

The contractor shall have a disaster recovery and back-up plan, of which a copy should be provided to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue services as specified under these specifications in the event of a disaster.

WW. TIME IS OF THE ESSENCE

Time is of the essence in this contract. The acceptance of late performance with or without objection or reservation by the State shall not waive any rights of the State nor constitute a waiver of the requirement of timely performance of any obligations on the part of the contractor remaining to be performed.

XX. RECYCLING

Preference will be given to items which are manufactured or produced from recycled material or which can be readily reused or recycled after their normal use as per state statute (Neb. Rev. Stat. §81-15, 159).

YY. DRUG POLICY

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

ZZ. NEW EMPLOYEE WORK ELIGIBILITY STATUS

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent

federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at www.das.state.ne.us.

2. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

3. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

AAA. RESERVED

IN WITNESS WHEREOF, the parties have executed this Addendum as of the date of execution by both parties below.

"State"	"Contractor"
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Implementation Guarantee

Prepared For:

State of Nebraska

Effective Date:

7/1/2019

Presented by:

Mutual of Omaha
11605 Miracle Hills Drive
Suite 101
Omaha, NE 68154

Thank you for considering Mutual of Omaha as your benefits provider. We are excited about the opportunity to partner with State of Nebraska. for group benefits and services that are unique to its needs.

Mutual of Omaha is committed to providing unparalleled service that will meet the needs of our customers. We recognize that for our prospects and eventual customers there are typically no timing guarantees during the implementation process when changing insurance providers. To address this concern we have developed an "Implementation Guarantee".

We are so confident that you will have a great experience with our implementation and service that we have outlined the Implementation guarantee below.

Mutual of Omaha will pay a one-time penalty of the lesser of $2,500 or 5% of total premium, if we do not meet the following time frames on implementation:

(1) Policy number issued within 9 business days from the date all necessary & complete information is received in the Home Office

(2) Booklets issued within 25 business days from the date all necessary & complete information is received in the Home Office

(3) Bills (List Bill) issued within 25 business days from the date all necessary & complete information is received in the Home Office.

Thank you again for allowing Mutual of Omaha to partner with State of Nebraska. We look forward to working with you!

Marketing Materials

Why Should You Offer Life Insurance Benefits for Your Employees?

Life insurance is an important part of an employee's benefits package. It can help provide financial security through some of life's most difficult transitions. Yet four out of 10 people do not own a life insurance policy in any amount, and two in 10 only have life insurance through a group member benefit.[1]

Whether you're married, single, starting a family or close to retirement, a life insurance policy can help minimize financial burdens. Life insurance can be used to:

- Pay medical and funeral bills
- Replace lost income
- Pay off a mortgage and other debts
- Fund college expenses

Without life insurance, the death of a wage earner could cause financial ruin for an employee and their loved ones who may live paycheck to paycheck.

So why do people choose to go without this valuable insurance coverage?

Twenty-seven percent of people believe they would not qualify for individual (life insurance) coverage.[2]

Reasons vary from health conditions to hobbies and lifestyle choices. Most people realize smoking or high blood pressure can make it more difficult to get life insurance. But who knew a few speeding tickets could result in higher premiums?

Voluntary Term Life Insurance – A Win-Win Scenario

By participating in a standard group voluntary life insurance plan, employees who might not otherwise be eligible for life insurance can obtain coverage.

With our voluntary term life insurance, your employees have the freedom to select adequate levels of life insurance coverage to help protect the well-being of their families. And, since premiums are paid entirely by the employee, ***there is no additional cost to your company.***

Additionally, our coverage is guarantee issue, premiums may be payroll deducted and annual increase options are available.

Voluntary term life insurance can help provide employees with a financial safety net that keeps their minds on their jobs and not on money concerns.

Contact me for more information.

[1] 2015 Life Insurance Statistics and Facts [2] 2016 LIMRA Life Insurance Barometer Study

174299

OUR CLAIMS STORY:

Life and Accidental Death & Dismemberment Insurance (AD&D)

Employees who file life and/or AD&D claims are already going through enough. The last thing they need is more stress and worry. To help ease the process we've created a streamlined claims approach.

With an average tenure of 20+ years, our life and AD&D claims technicians will provide service that is:

- **Simplified** – Only one claim form needs to be submitted for both life and AD&D policies, saving time and effort
- **Flexible** – We offer a variety of convenient ways to file a claim and are flexible in what's required to process and manage the claim
- **Proactive** – We do a lot of legwork such as seeking proof, obtaining paperwork, and paying for necessary records
- **Fast** – A decision of pay, pend or deny will be made within two days of claim receipt

LIFE WAIVER OF PREMIUM CLAIM PROCESS

We understand that managing leave can be complex. We are here to help you understand the life waiver of premium claims process and make it as seamless as possible.

- To qualify for a waiver of premium on a life insurance policy an employee must:
  - Satisfy the waiver elimination period stated in the policy
  - Be totally disabled from any occupation at the end of the elimination period
  - Be under the age of 60 at the time of total disability
  - Continue to pay premium during the elimination period until the waiver is approved

Express Pay

If the benefit amount is less than $100,000, a life claim can be paid quickly without an original death certificate. Other forms of proof, like an obituary, can be used to ensure an employee is paid fast.

- If your employee's coverage will not be continued under the policy while they are satisfying the waiver elimination period, they have 31 days from the start of their disability leave to convert or port their policy; otherwise, they risk losing coverage
- If your employee has our Long-Term Disability Income Insurance (LTD) coverage, we set up the life waiver of premium claim for them (seamless process for life waiver)
  - If your employee does not have our LTD coverage, they must submit a waiver claim and proof of total disability by the end of the elimination period
- Our dedicated waiver technicians will help individuals set up a waiver claim and perform annual status reviews
- If a life waiver claim is approved, premium will continue to be waived through the duration of an employee's disability benefit, as defined in their policy

WE PROTECT WHAT MATTERS MOST

For more than a century, we've been committed to listening to our customers and helping them through life's transitions by providing an array of insurance, financial and banking products.

Contact me to learn more.

Account Manager
Bios

› Ryan Klaus GBDS

ASSOCIATE ACCOUNT MANAGER

Mutual of Omaha

3300 Mutual of Omaha Plaza
Omaha, NE 68175

402-351-6639

ryan.klaus@mutualofomaha.com

Ryan is very thorough in his work and is a true advocate for his customers. His expertise in administrative support allows him to create solutions that drive customer satisfaction.

Ryan Klaus has been working in the customer service industry since 1997. He began his career with Mutual of Omaha in 2010 as a Senior Client Representative and was promoted to Associate Account Manager this year.

Ryan is known for his excellent time management skills and attention to detail. His customers and brokers appreciate his expertise with eligibility questions, implementation, billing, contract explanations and claims inquiries.

Because of his ability to build professional relationships and provide excellent customer service, Ryan serves as a liaison between the sales and service teams to research and resolve issues. He also mentors newly hired employees on the service team and assists with the onboarding process.

Ryan earned his Group Benefits Disability Specialist designation in 2013 and his Nebraska Life and Annuities, Sickness, Accident and Health license in 2010.

Here is what Ryan does for you:

- Serves as a dedicated point of contact
- Oversees ongoing business partnerships
- Provides centralized account management
- Recommends administrative efficiencies
- Shares knowledge of best practices
- Educates and guides administrators through Mutual of Omaha processes
- Ensures collaboration of resources required to manage plan administration

Audited Financial
Statement

United of Omaha Life Insurance Company

A Wholly Owned Subsidiary of
(Mutual of Omaha Insurance Company)

Statutory Financial Statements as of December 31, 2017 and 2016, and for the Years Ended December 31, 2017, 2016, and 2015, Supplemental Schedules as of and for the Year Ended December 31, 2017, and Independent Auditors' Report

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

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First National Tower
1601 Dodge Street
Suite 3100
Omaha, NE 68102-1640
USA

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www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Board of Directors
United of Omaha Life Insurance Company
Omaha, Nebraska

We have audited the accompanying statutory-basis financial statements of United of Omaha Life Insurance Company (the "Company") (a wholly owned subsidiary of Mutual of Omaha Insurance Company), which comprise the statutory-basis statements of admitted assets, liabilities, and surplus as of December 31, 2017 and 2016, and the related statutory-basis statements of operations, changes in surplus, and cash flows for each of the three years in the period ended December 31, 2017, and the related notes to the statutory-basis financial statements.

Management's Responsibility for the Statutory-Basis Financial Statements

Management is responsible for the preparation and fair presentation of these statutory-basis financial statements in accordance with the accounting practices prescribed or permitted by the State of Nebraska Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these statutory-basis financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the statutory-basis financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the statutory-basis financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the statutory-basis financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the statutory-basis financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the statutory-basis financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on Accounting Principles Generally Accepted in the United States of America

As described in Note 1 to the statutory-basis financial statements, the statutory-basis financial statements are prepared by United of Omaha Life Insurance Company using the accounting practices prescribed or permitted by the State of Nebraska Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America, to meet the requirements of the State of Nebraska Department of Insurance.

The effects on the statutory-basis financial statements of the variances between the statutory-basis of accounting described in Note 1 to the statutory-basis financial statements and accounting principles generally accepted in the United States of America; although not reasonably determinable, are presumed to be material.

Adverse Opinion on Accounting Principles Generally Accepted in the United States of America

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on Accounting Principles Generally Accepted in the United States of America paragraph, the statutory-basis financial statements referred to above do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of United of Omaha Life Insurance Company as of December 31, 2017 and 2016, or the results of its operations or its cash flows for each of the three years in the period ended December 31, 2017.

Opinion on Statutory Basis of Accounting

In our opinion, the statutory-basis financial statements referred to above present fairly, in all material respects, the admitted assets, liabilities, and surplus of United of Omaha Life Insurance Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in accordance with the accounting practices prescribed or permitted by the State of Nebraska Department of Insurance as described in Note 1 to the statutory-basis financial statements.

Deloitte & Touche LLP

April 19, 2018

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

STATUTORY STATEMENTS OF ADMITTED ASSETS, LIABILITIES, AND SURPLUS
AS OF DECEMBER 31, 2017 AND 2016

	2017	2016
ADMITTED ASSETS		
CASH AND INVESTED ASSETS:		
Bonds	$ 14,898,437,642	$ 13,797,081,508
Preferred stocks	131,800,000	28,800,000
Common stocks — unaffiliated	47,958,719	23,036,400
Common stocks — affiliated	117,179,140	110,249,977
Mortgage loans — net	2,118,511,798	2,000,163,314
Real estate occupied by the Company — net of accumulated depreciation of $93,738,865 and $90,944,932, respectively	48,610,811	49,554,692
Real estate held for sale	-	396,900
Contract loans	184,171,324	179,965,773
Cash and cash equivalents	(4,408,157)	51,472,241
Short-term investments	104,786,154	50,000,000
Securities lending cash collateral	287,498,568	154,808,895
Other invested assets	192,038,263	213,428,353
Total cash and invested assets	18,126,584,262	16,658,958,053
INVESTMENT INCOME DUE AND ACCRUED	140,086,313	129,900,575
PREMIUMS DEFERRED AND UNCOLLECTED	239,338,427	215,070,113
REINSURANCE RECOVERABLE	164,646,349	153,485,454
NET DEFERRED TAX ASSETS	90,804,787	134,613,940
OTHER ASSETS	43,824,661	28,426,038
SEPARATE ACCOUNT ASSETS	3,997,964,477	3,377,775,288
TOTAL ADMITTED ASSETS	$ 22,803,249,276	$ 20,698,229,461
LIABILITIES AND SURPLUS		
LIABILITIES:		
Policy reserves:		
Reserves for life policies and contracts	$ 11,316,572,960	$ 10,413,337,671
Deposit-type contracts	2,827,783,339	2,691,722,811
Health and accident active life	91,733,969	85,950,238
Total policy reserves	14,236,090,268	13,191,010,720
Claim reserves:		
Policy and contract claims — life	93,199,247	82,222,373
Policy and contract claims — health	762,674,900	731,471,345
Total claim reserves	855,874,147	813,693,718
Premiums paid in advance	25,154,067	25,362,322
Interest maintenance reserve	25,105,099	17,063,974
Asset valuation reserve	145,770,838	122,405,601
General expenses and taxes due or accrued	73,534,869	51,933,478
Payable to parent, subsidiaries, and affiliates — net	132,317,915	116,663,084
Borrowings	346,842,061	225,107,295
Funds held under coinsurance	1,114,811,241	1,107,118,053
Other liabilities	244,066,963	220,583,357
Separate account liabilities	3,997,964,477	3,377,775,288
Total liabilities	21,197,531,945	19,268,716,890
SURPLUS:		
Capital stocks, $10 par value, 900,000 shares authorized, issued and outstanding	9,000,000	9,000,000
Gross paid-in and contributed surplus	582,558,051	582,558,051
Special surplus	314,716	-
Unassigned surplus	1,013,844,564	837,954,520
Total surplus	1,605,717,331	1,429,512,571
TOTAL LIABILITIES AND SURPLUS	$ 22,803,249,276	$ 20,698,229,461

See notes to statutory financial statements.

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

STATUTORY STATEMENTS OF OPERATIONS
FOR THE YEARS ENDED DECEMBER 31, 2017, 2016 AND 2015

	2017	2016	2015
INCOME:			
Net premiums and annuity considerations	$ 4,024,870,572	$ 3,692,085,072	$ 3,572,460,647
Net investment income	742,432,796	702,647,668	828,993,447
Commissions and expense allowances on reinsurance ceded	150,017,522	106,978,078	86,792,950
Other income	37,976,396	34,438,032	36,924,199
Total income	4,955,297,286	4,536,148,850	4,525,171,243
BENEFITS AND EXPENSES:			
Policyholder benefits	2,534,939,125	2,635,808,148	2,668,812,360
Increase in reserves	913,792,176	569,658,040	499,191,656
Commissions	472,900,474	448,052,058	404,720,170
Operating expenses	916,966,757	849,981,695	736,816,890
Total benefits and expenses	4,838,598,532	4,503,499,941	4,309,541,076
NET GAIN FROM OPERATIONS BEFORE FEDERAL INCOME TAX EXPENSE AND NET REALIZED CAPITAL LOSSES	116,698,754	32,648,909	215,630,167
FEDERAL INCOME TAX EXPENSE	43,123,221	23,569,907	38,273,444
NET GAIN FROM OPERATIONS BEFORE NET REALIZED CAPITAL LOSSES	73,575,533	9,079,002	177,356,723
NET REALIZED CAPITAL LOSSES — Net of taxes (benefits) of $3,961,385, $(1,212,222), and $1,468,554, and transfers to (from) the interest maintenance reserve of $11,430,362, $(704,192), and $1,401,547, respectively	(11,845,687)	(67,427)	(23,716,607)
NET INCOME	$ 61,729,846	$ 9,011,575	$ 153,640,116

See notes to statutory financial statements.

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

STATUTORY STATEMENTS OF CHANGES IN SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 2017, 2016 AND 2015

	2017	2016	2015
CAPITAL STOCK	$ 9,000,000	$ 9,000,000	$ 9,000,000
GROSS PAID-IN AND CONTRIBUTED SURPLUS	582,558,051	582,558,051	582,558,051
SPECIAL SURPLUS:			
Balance — beginning of year	-	188,293	-
Increase (decrease) in aggregate write-ins	314,716	(188,293)	188,293
Balance — end of year	314,716	-	188,293
UNASSIGNED SURPLUS:			
Balance — beginning of year	837,954,520	849,971,791	831,165,140
Net income	61,729,846	9,011,575	153,640,116
Dividends paid	-	(96,893,320)	-
Change in:			
Net unrealized capital gains (losses) — net of taxes (benefits) of $3,528,765, $(3,013,887), and $(29,204,215), respectively	127,509,106	13,011,251	(75,903,694)
Foreign exchange unrealized capital gains (losses) — net of taxes (benefits) of $(1,693,148), $(6,397,183), and $885,127, respectively	(6,369,460)	(11,880,483)	1,643,807
Net deferred income taxes	(73,181,690)	(8,860,779)	(3,344,152)
Nonadmitted assets	11,798,073	(8,793,465)	(43,060,193)
Reserve on account of change in valuation basis	(19,268,784)	(11,085,245)	(53,185,427)
Asset valuation reserve	(23,365,237)	(7,044,903)	43,045,643
Deferred gain (loss) on reinsurance	97,352,906	110,329,805	(3,841,156)
Aggregate write-ins	(314,716)	188,293	(188,293)
Balance — end of year	1,013,844,564	837,954,520	849,971,791
TOTAL SURPLUS	$ 1,605,717,331	$ 1,429,512,571	$ 1,441,718,135

See notes to statutory financial statements.

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

STATUTORY STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2017, 2016 AND 2015

	2017	2016	2015
CASH FROM (USED FOR) OPERATIONS:			
Net premiums and annuity considerations	$ 4,177,933,878	$ 4,027,342,652	$ 3,657,204,398
Net investment income	724,568,323	686,084,298	729,634,818
Other income	117,651,763	113,206,403	111,460,256
Policyholder benefits	(2,587,650,749)	(2,755,534,999)	(2,731,036,354)
Net transfers (to) from separate accounts	(250,778)	(78,703)	238,575
Commissions and operating expenses	(1,299,484,952)	(1,203,177,105)	(1,080,267,112)
Federal income taxes paid to parent	(38,400,728)	(34,407,646)	(16,880,438)
Net cash from operations	1,094,366,757	833,434,900	670,354,143
CASH FROM (USED FOR) INVESTMENTS:			
Proceeds from investments sold, matured or repaid:			
Bonds	2,216,635,328	1,591,913,023	1,670,516,463
Stocks	87,552,402	53,408,644	16,680,246
Mortgage loans	281,412,466	246,701,849	325,887,167
Real estate	2,467,580	777,251	2,128,050
Other invested assets	20,769,186	36,073,102	58,044,454
Net gains (losses) on cash, cash equivalents, and short-term investments	1,511	(1,412)	(985)
Miscellaneous proceeds	12,069,281	1,157,790	7,072,196
Cost of investments acquired:			
Bonds	(3,143,397,015)	(2,800,344,659)	(2,557,947,905)
Stocks	(131,753,600)	(6,124,600)	(52,710,400)
Mortgage loans	(398,750,389)	(419,557,666)	(379,111,785)
Real estate	(4,023,089)	(2,548,222)	(737,768)
Other invested assets	(66,420,347)	(14,641,070)	(16,160,935)
Miscellaneous applications	(5,338,686)	(13,446,280)	-
Net (increase) decrease in contract loans	(5,032,540)	(577,837)	1,570,779
Net cash used for investments	(1,133,807,912)	(1,327,210,087)	(924,770,423)
CASH FROM (USED FOR) FINANCING AND MISCELLANEOUS SOURCES:			
Borrowed funds (paid) received	(10,909,092)	(75,909,092)	54,090,908
Net increase in deposit-type contracts	136,060,529	151,936,182	216,862,668
Net increase (decrease) in payable to parent	15,654,831	14,804,228	(17,219,916)
Other cash (applied) provided	(102,459,357)	4,912,387	937,280
Net cash from financing and miscellaneous sources	38,346,911	95,743,705	254,670,940
NET CHANGE IN CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS	(1,094,244)	(398,031,482)	254,660
CASH, CASH EQUIVALENTS, AND SHORT-TERM INVESTMENTS:			
Beginning of year	101,472,241	499,503,723	499,249,063
End of year	$ 100,377,997	$ 101,472,241	$ 499,503,723

(Continued)

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

STATUTORY STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2017, 2016 AND 2015

	2017	2016	2015
NON-CASH TRANSACTIONS:			
Omaha Reinsurance Company ceded premium settled through funds withheld	$233,352,638	$ 332,482,986	$ 152,806,118
Stock and bond conversions	$303,780,926	$ 127,995,665	$ 116,015,508
Omaha Reinsurance Company ceded benefits settled through funds withheld	$ 90,400,213	$ 83,378,381	$ 76,646,063
Omaha Reinsurance Company ceded commissions settled through funds withheld	$ 68,629,690	$ 26,323,850	$ 9,950,282
Omaha Reinsurance Company ceded interest settled through funds withheld	$ 51,139,021	$ 45,611,612	$ 41,287,000
Companion assumed premium settled through funds withheld	$ 29,095,959	$ 27,750,717	$ 27,461,888
Capital contribution through payable to subsidiary	$ 27,000,000	$ -	$ 5,000,000
Companion assumed benefits settled through funds withheld	$ 21,466,803	$ 17,152,522	$ 18,338,775
Funds withheld listed as current amounts receivable	$ 14,456,754	$ 20,148,796	$ 6,038,925
Omaha Reinsurance Company ceded policy loans settled through funds withheld	$ 4,664,187	$ 3,825,826	$ 2,846,503
Companion assumed commissions settled through funds withheld	$ 4,185,231	$ 4,167,552	$ 4,486,165
Companion assumed interest settled through funds withheld	$ 1,708,376	$ 1,510,740	$ 1,319,126
Dividend paid in the form of other invested assets	$ -	$ 96,893,320	$ -
Capital distribution - from affiliated LLC	$ -	$ -	$ 78,655,132
Mortgage loan conversions disposed to mortgage loan conversions acquired	$ -	$ -	$ 30,407,771

See notes to statutory financial statements.

(Concluded)

1. NATURE OF OPERATIONS AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Operations — United of Omaha Life Insurance Company (the "Company") is a wholly owned subsidiary of Mutual of Omaha Insurance Company ("Mutual of Omaha"), a mutual health and accident and life insurance company, domiciled in the State of Nebraska. The following are wholly owned subsidiaries of the Company: Companion Life Insurance Company ("Companion"); United World Life Insurance Company ("United World"); Property and Casualty Company of Omaha (formerly known as Omaha Life Insurance Company); UM Holdings, L.L.C.; Omaha Reinsurance Company ("Omaha Re") and Mutual of Omaha Structured Settlement Company.

The Company provides a wide array of financial products and services to a broad range of institutional and individual customers and is licensed in 49 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. Principal products and services provided include individual and group health insurance, individual and group life insurance, annuities, and retirement plans.

Basis of Presentation — The accompanying statutory financial statements have been prepared in conformity with accounting practices prescribed or permitted by the State of Nebraska Department of Insurance ("NDOI"). The State of Nebraska has adopted the National Association of Insurance Commissioners' ("NAIC") Statutory Accounting Principles ("SAP") as the basis of its statutory accounting practices. The Commissioner of the NDOI has the right to permit other specific practices that may deviate from NAIC SAP. The Company does not utilize any permitted practices.

The State of Nebraska employed a prescribed accounting practice for synthetic guaranteed interest contracts ("synthetic GICs") that differs from NAIC SAP in how reserves are determined. The following is a reconciliation of the Company's net income and statutory surplus between the prescribed accounting practices and NAIC SAP as of and for the years ended December 31:

	2017	2016	2015
Net income, Nebraska basis	$ 61,729,846	$ 9,011,575	$ 153,640,116
Nebraska prescribed practice: synthetic GICs	147,409	359,513	(2,407,501)
Net income, NAIC SAP	$ 61,877,255	$ 9,371,088	$ 151,232,615
Statutory surplus, Nebraska basis	$ 1,605,717,331	$ 1,429,512,571	$ 1,441,718,135
Nebraska prescribed practice: synthetic GICs	7,783,006	7,635,597	7,276,083
Statutory surplus, NAIC SAP	$ 1,613,500,337	$ 1,437,148,168	$ 1,448,994,218

The prescribed practice is reflected in net income as an increase in reserve and reserve in liabilities as reserve for life policies and contracts.

The accompanying statutory financial statements vary in some respects from those that would be presented in conformity with accounting principles generally accepted in the United States of America ("GAAP"). The most significant differences include:

a. Bonds are generally carried at amortized cost, while under GAAP, they are carried at either amortized cost or fair value based upon their classification according to the Company's ability and intent to hold or trade the bonds and whether the Company has elected the option to report bonds at fair value. Exchange Traded Funds, eligible for bond reporting by the NAIC Securities Valuation Office ("SVO Identified Funds-ETFs"), are carried at fair value and classified as bonds, while under GAAP, they are carried at fair value and classified as equity.

b. An other-than-temporary impairment ("OTTI") exists for NAIC SAP on a loan-backed or structured security if the fair value is less than the amortized cost basis and the Company has the intent to sell, does not have the intent and ability to retain the investment for a period of time sufficient to recover the amortized cost basis, or the Company does not expect to recover the entire amortized cost basis. For all other securities on an NAIC SAP basis, an OTTI is recognized if it is probable that the reporting entity will be unable to collect all amounts due according to the contractual terms of the security in effect at the date of acquisition or since the last OTTI. An OTTI exists for GAAP if a security's fair value is less than amortized cost and if the Company has the intent to sell, it is more likely than not that the Company will be required to sell before the recovery of the amortized cost basis, or if the Company does not expect to recover the entire amortized cost of the security.

c. Investments in preferred stocks are generally carried at amortized cost or cost, while under GAAP, preferred stocks are carried at their estimated fair value or cost.

d. Limited partnerships are carried at the underlying audited GAAP equity value with the change in valuation reflected in unassigned surplus on an NAIC SAP basis. Income distributions for the limited partnerships are reported as net investment income on an NAIC SAP basis. Under GAAP, the change in valuation as well as the income distributions are reflected in either net investment income or as a realized capital gain or loss depending on the underlying investments.

e. Under NAIC SAP, derivative instruments that meet the criteria of an effective hedge are valued and reported in a manner that is consistent with the hedged asset or liability. The change in fair value of derivative instruments that do not meet the criteria of an effective hedge are recorded as an unrealized capital gain or loss in surplus. Under GAAP, all derivatives are reported on the balance sheet at fair value and the effective and ineffective portions of a single hedge are accounted for separately. Changes in fair value of derivatives, to the extent they are effective at offsetting hedged risk, are recorded through either income or equity, depending on the nature of the hedge. The ineffective portion of all changes in fair value is recorded in income.

f. Acquisition costs, such as commissions and other costs directly related to acquiring new business, are charged to operations as incurred, while under GAAP, to the extent associated with successful sales and recoverable from future policy revenues, are deferred and amortized to income as premiums are earned or in relation to estimated gross profits.

g. NAIC SAP requires an amount to be recorded for deferred taxes as a component of surplus; however, there are limitations as to the amount of deferred tax assets ("DTAs") that may be reported as admitted assets that are not applicable under GAAP. Federal income tax provision is required on a current basis for the statutory statements of operations, the same as for GAAP.

h. NAIC SAP policy reserves for life insurance and annuities are based on mortality, lapse, and interest assumptions prescribed or permitted by state statutes. For health insurance, mortality and interest are prescribed, and morbidity and lapse assumptions are Company estimates with statutory limitations. The effect on reserves, if any, due to a change in valuation basis, is recorded directly to unassigned surplus rather than included in the determination of net gain (loss) from operations. GAAP policy reserves are based on the Company's estimates of morbidity, mortality, interest, and withdrawals.

i. The asset valuation reserve ("AVR") and interest maintenance reserve ("IMR") are established only in the statutory financial statements.

j. Assets are reported under NAIC SAP at admitted asset value and nonadmitted assets are excluded through a charge to surplus, while under GAAP, nonadmitted assets are reinstated to the balance sheet, net of any valuation allowance.

k. Premium receipts and benefits on universal life-type contracts and deferred annuities are recorded as income and expense under NAIC SAP. Under GAAP, revenues on universal life-type contracts and deferred annuities are comprised of contract charges and fees that are recognized when assessed against the policyholder account balance. In addition, certain of the revenue as defined under deposit accounting is deferred and amortized to income over the expected life of the contract using the product's estimated gross profits, similar to acquisition costs. Premium receipts and benefits paid are considered deposits and withdrawals, respectively, and are recorded as or against interest-bearing liabilities.

l. Reinsurance recoverables on unpaid losses are reported as a reduction of policy reserves, while under GAAP, they are reported as an asset.

m. Comprehensive income and its components are not presented in the statutory financial statements.

n. Subsidiaries are included as common stocks carried under the equity method, with the equity in the operating results of subsidiaries credited or charged directly to the Company's surplus for NAIC SAP. Dividends received from subsidiaries are recorded in net investment income. GAAP requires either consolidation or equity method reporting with operating results of subsidiaries reflected in the statements of operations.

o. For loss contingencies, when no amount within management's estimate of a range is a better estimate than any other amount, the midpoint of the range is accrued. Under GAAP, the minimum amount in the range is accrued.

p. Gains on economic transactions, defined as arm's-length transactions that result in the transfer of the risks and rewards of ownership, with related parties are recognized and deferred in surplus under NAIC SAP rather than deferred until the assets are sold to third parties as required under GAAP.

Use of Estimates — The preparation of statutory financial statements in accordance with NAIC SAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the statutory financial statements, and reported amounts of revenues and expenses during the reporting period. The most significant estimates and assumptions include those used in determining investment valuation in the absence of quoted market values, impairments, reserves for policies and contracts, policy and contract claims, and deferred taxes. Actual results could differ from those estimates.

The process of determining the fair value and recoverability of an asset relies on projections of future cash flows, operating results, and market conditions. Projections are inherently uncertain and, accordingly, actual future cash flows may differ materially from projected cash flows. As a result, the Company's asset valuations are susceptible to the risk inherent in making such projections.

Due to the length and complexity of annuity and life insurance contracts and the risks involved, policy reserves calculated using regulatory prescribed methods and assumptions are often not closely related to the economic liability for the benefits and options promised to policyholders. Reserves are determined using prescribed mortality tables and interest rate assumptions. Prescribed lapse assumptions are permitted on certain universal life contracts. Certain guarantees embedded in the contracts are defined formulaically. Actual mortality, lapse, interest rates, and the nature of the guarantees, will differ from prescribed assumptions and definitions.

Due to the nature of health and accident contracts and the risks involved, health and accident active life reserves are estimates. These reserves are calculated using morbidity mortality, and interest rate assumptions. Voluntary lapse assumptions are permitted in certain situations subject to limitations for certain products. Actual morbidity, mortality, interest rates, and voluntary lapse rates may differ from valuation assumptions.

Policy and contract claims are estimated based upon the Company's historical experience and other actuarial assumptions that consider the effects of current developments, anticipated trends, and risk management programs. Revisions of these estimates are reflected in operations in the year they are made.

Investments — Investments are reported according to valuation procedures prescribed by the NAIC. Bonds are stated at amortized cost using the effective yield method, except for bonds with an NAIC designation of 6, which are stated at lower of amortized cost or fair value. The use of fair value may cause some of the loan-backed securities previously designated as NAIC 6 to be reassigned to a different designation. SVO Identified investments, captured within the scope of Statement of Statutory Accounting Principles ("SSAP") No. 26 *Bonds*, are eligible for bond reporting. The Company has elected to value SVO Identified investments at fair value.

Premiums and discounts on loan-backed bonds and structured securities are amortized using the retrospective or prospective method based on anticipated prepayments from the date of purchase. Prepayment assumptions are based on information obtained from brokers or internal estimates based on original term sheets, offer memoranda, historical performance, or other forecasts. Changes in estimated cash flows due to changes in estimated prepayments are accounted for using the prospective method for impaired securities and the retrospective method for all other securities.

Preferred stocks redeemable and perpetual, are stated at amortized cost; except for preferred stocks that are NAIC rated 4 through 6, which are stated at lower of amortized cost or fair value.

Common stocks of unaffiliated companies are stated at fair value and common stocks of affiliated insurance companies are carried at the underlying statutory equity value while affiliated non-insurance companies are carried at the GAAP equity value. Changes in the carrying values are recorded as a change in net unrealized capital gains (losses), a component of surplus. Dividends are reported in net investment income.

Mortgage loans held for investment are carried at the aggregate unpaid principal balance adjusted for unamortized premium or discount, except impaired loans. Such loans are carried at the lower of the principal balance, or the fair value of the loan determined by the present value of expected future cash flows discounted at the loan's effective interest rate, the loan's observable market price, or the fair value of the collateral less cost to sell if collateral dependent. Interest income is accrued on the unpaid principal balance based on the loan's contractual interest rate. The Company records a reserve for losses on mortgage loans as part of the AVR.

The Company calculates specific reserves on loans identified individually as impaired. Loans evaluated individually are considered impaired when, based on current information and events, it is probable that the Company will be unable to collect principal or interest amounts according to the contractual terms of the loan agreement. Interest income earned on impaired loans is accrued on the principal amount of the loan based on the loan's contractual interest rate until the loan is placed on non-accrual status.

Loans are reviewed on an individual basis to identify charge-offs. Charge-offs, net of recoveries, are deducted from the allowance. Mortgage loans are considered past due if the required principal and interest payments have not been received when contractually due. All mortgage loans are in non-accrual status when payments are determined to be uncollectable. Mortgage loans are returned to accrual status when all the principal and interest amounts contractually due have been brought current and future payments are reasonably assured.

A mortgage loan is considered a troubled debt restructuring ("TDR") if the borrower is experiencing financial difficulties and the Company has granted a concession it would not otherwise consider. A TDR typically involves a modification of terms such as a change of the interest rate to a below market rate, a forgiveness of principal or interest, an extended repayment period (maturity date) at a contractual interest rate lower than the current interest rate for new debt with similar risk, or capitalization and deferral of interest payments.

Real estate, excluding real estate held for sale, is valued at cost, less accumulated depreciation. Depreciation is provided on the straight-line method over the estimated useful lives, generally forty years, of the related assets. Real estate held for sale is valued at the lower of depreciated cost or fair value less estimated costs to sell. Real estate held for sale consists of collateral received on foreclosed mortgage loans.

Contract loans are carried at unpaid principal balances.

Cash equivalents are highly liquid debt securities purchased with an original maturity of less than three months. Cash equivalents are carried at cost, which approximates fair value.

Short-term investments include investments whose original maturities at the time of purchase are three months to one year and are stated at cost, which approximates fair value.

The Company has securities lending agreements whereby unrelated parties, primarily major brokerage firms, borrow securities from the Company. The Company requires a minimum of 102% and 105% of the fair value of the domestic and foreign securities, respectively, loaned at the outset of the contract as collateral. The Company continues to retain control over and receive interest on loaned securities, and accordingly, the loaned securities continue to be reported as bonds. The securities loaned are on open terms and can be returned to the Company on the next business day requiring a return of the collateral. Collateral received is invested in cash equivalents and securities with a corresponding liability for funds held for securities on loan included in borrowings in the statutory financial statements. The Company cannot access the collateral unless the borrower fails to deliver the loaned securities. To further minimize the credit risks related to this securities lending program, the Company regularly monitors the financial condition of counterparties to these agreements and also receives an indemnification from the financial intermediary who structures the transactions.

Other invested assets include investments in limited partnerships, receivables for securities, and an approximately 80% ownership of Fulcrum Growth Partners, L.L.C. and Fulcrum Growth Partners III L.L.C (collectively "Fulcrum"). The Company currently recognizes 80% of the contributions and distributions of Fulcrum in its investment in Fulcrum and 72% of net income (loss) based on the partnership agreement provisions. Limited partnerships and the investment in Fulcrum are carried at their underlying GAAP equity, which approximates fair value, with a one quarter lag adjusted for all capital distributions, cash distributions, and impairment charges for the quarter with changes recorded in unrealized capital gains (losses) through surplus. Distributions of income from these investments are recorded in net investment income.

Fulcrum was established for the purpose of investing in nontraditional assets, including private equities, public equities, special situation real estate equities and mezzanine debt. Fulcrum is capitalized through the contributions of the Company and one other owner. Contributions are no longer accepted by Fulcrum. The Company's investment in Fulcrum in the statements of admitted assets, liabilities, and surplus and net investment income in the statutory statements of operations was as follows:

	2017	2016	2015
As of and for the year ended December 31:			
Investment in Fulcrum	$ 59,535,910	$ 60,277,418	$ 61,694,454
Net investment income	$ 1,627,704	$ 9,349,319	$ 127,035,073

Fulcrum's assets, liabilities, and results of operations as of and for the nine months ended September 30, were as follows:

	2017	2016	2015
Assets	$ 84,546,074	$ 85,579,144	$ 107,369,016
Liabilities	$ 137,768	$ 128,757	$ 126,979
Net income	$ 795,751	$ 9,799,797	$ 17,522,640

The Company uses derivative financial instruments to reduce exposure to market volatility associated with assets held or liabilities incurred and to change the characteristics of the Company's asset/liability mix, consistent with the Company's risk management activities. The Company writes certain of the options purchased on indexed universal life for Companion, its wholly owned subsidiary.

Derivatives include foreign currency swaps, swaptions, interest rate swaps, warrants, and call spread options. When derivative financial instruments meet specific criteria, they may be designated as accounting hedges and accounted for on an amortized cost basis, in a manner consistent with the item hedged. Derivative financial instruments that are not designated as accounting hedges are accounted for on a fair value basis with changes recorded as a change in net unrealized capital gains (losses) within the statutory statements of changes in surplus. Net settlement amounts on interest rate swaps are recorded as adjustments to net investment income on an accrual basis over the life of the swap. Interest on currency swaps is included in net investment income.

The Company designates certain of its foreign currency swaps as cash flow hedges when they are highly effective in offsetting the exposure of variations in cash flows for the hedged item. The Company designates certain of its interest rate swaps as fair value hedges when they are highly effective in offsetting the risk of changes in the fair value of the hedged item. For interest rate swaps, the Company is exposed to credit-related losses in the amount of the net interest differential in the event of non-performance by the swap counterparty. For currency swaps and forwards, the Company is exposed to credit-related losses in the amount of the net currency differential in the event of non-performance by the swap counterparty.

The Company uses swaptions to mitigate interest rate risk. Under a swaption, the Company pays a one-time premium to the counterparty while the counterparty agrees to deliver at expiration the value of the underlying swap if that value is positive. The Company's swaptions are not highly correlated or effective so they do not qualify for hedge accounting. Changes in the fair value of the swaptions are included in net unrealized capital gains (losses) within the statutory statements of changes in surplus.

The Company uses call spread options to hedge the crediting rates under equity indexed universal life products to mitigate interest rate fluctuations. The Company received warrants in the course of bond restricting that once exercised can be converted to common stock. The Company does not consider either derivative type as hedges, so changes in the fair value of the options are included in net unrealized capital gains (losses) within the statutory statements of changes in surplus.

Investment income consists primarily of interest and dividends. Interest is recognized on an accrual basis and dividends are recorded as earned at the ex-dividend date. Interest income on mortgage-backed securities ("MBS") and asset-backed securities ("ABS") is determined on the effective yield method based on estimated principal repayments. Accrual of income is suspended when securities are in default or when the receipt of interest payments is in doubt. Realized capital gains (losses) on the sale of investments are determined on the specific identification basis.

Investment income due or accrued for which it is probable the balance is uncollectible is written off and charged to investment income. Investment income due or accrued deemed collectible on mortgage loans in default that is more than 180 days past due is nonadmitted. All other investment income due or accrued deemed collectible that is more than 90 days past due is nonadmitted.

Property — Property is carried at cost less accumulated depreciation and amortization and is included in other assets. The Company provides for depreciation of property using the straight-line method over the estimated useful lives of the assets. Furniture and fixtures are generally depreciated over four to twenty years. There were $1,124,870, $89,038, and $7,865,131 in fully depreciated write-offs of home office property no longer in use in 2017, 2016, and 2015, respectively. Depreciation and amortization expense was $4,806,093, $4,537,558, and $4,292,526 for the years ended December 31, 2017, 2016, and 2015, respectively.

Separate Accounts — The assets of the separate accounts in the statutory statements of admitted assets, liabilities, and surplus are carried at fair value and consist primarily of common stocks and mutual funds held by the Company for the benefit of contract holders under specific individual annuity and life insurance contracts and group annuity contracts. Separate account assets are segregated and are not subject to claims that arise out of any other business of the Company. Deposits and premiums received from and benefits paid to separate account contract holders are reflected in the statutory statements of operations net of reinsurance, but are offset by transfers to and from the separate account. Mortality, policy administration, and surrender charges from all separate accounts are included in other income.

Policy Reserves — Policy reserves include life insurance and annuity reserves, active life and unearned premium reserves for health contracts, and reserves for deposit-type contracts.

Life insurance reserves provide amounts adequate to discharge estimated future obligations in excess of estimated future net premiums on policies in force. Such reserves are valued using the net level premium method, the Commissioners' Reserve Valuation Method, or other modified reserve methods. Interest rate assumptions ranged from 2.50% to 6.00% for the years ending December 31, 2017 and 2016. Reserves for individual fixed annuities and supplementary contracts in payout status with life contingencies are maintained using the net level premium method or the Commissioners' Annuity Reserve Valuation Method, with appropriate statutory interest and mortality assumptions computed on the basis of interest ranging from 3.50% to 9.25% for the years ended December 31, 2017 and 2016. Group annuity reserves are valued using the net single premium method with statutory interest and mortality assumptions computed on the basis of interest ranging from 3.50% to 11.25% for the years ended December 31, 2017 and 2016.

Active life reserves for health contracts provide amounts adequate to discharge estimated future obligations in excess of estimated future net premiums on policies in force. Such reserves are based on statutory mortality and interest assumptions. Morbidity assumptions are either industry experience or a blend of industry and Company experience. Voluntary lapse assumptions, when applicable, are based on Company experience with statutory limitations. Such reserves are calculated on a net level premium method or on a one- or two-year preliminary term basis.

Unearned premium reserves are for premiums that have been paid but have not been earned.

Reserves for deposit-type contracts are equal to deposits received and interest credited to the benefit of contract holders, less withdrawals that represent a return to the contract holder. Reserves for annuities certain and supplementary contracts in payout status without life contingencies are determined using a net level premium method. Tabular interest on deposit-type contracts is calculated by formula as described in the NAIC instructions.

Claim Reserves — Claim reserves include the amounts estimated for claims that have been reported but not settled and estimates for claims incurred but not reported, and disabled life reserves. Such reserves are estimated based upon the Company's and affiliates' historical experience and other actuarial assumptions that consider the effects of current developments, anticipated trends, and risk management programs. Disabled life reserves are determined within statutory interest assumption limitations. Continuance assumptions are based on either industry experience or a blend of Company and industry experience that comply with statutory guidelines. Revisions of these estimates are reflected in operations in the year they are made. Claim adjustment expenses are accrued and included in operating expenses.

Reinsurance — In the normal course of business, the Company assumes and cedes insurance business in order to limit its maximum loss, provide greater diversification of risk, minimize exposures on larger risks and expand certain business lines. The ceding of insurance business does not discharge an insurer from its primary legal liability to a policyholder. The Company remains liable to the extent that a reinsurer is unable to meet its obligations. Amounts recoverable from reinsurers are reviewed for collectability on a quarterly basis. All amounts deemed uncollectible are written off through a charge to the statutory statements of operations when the uncollectibility of amounts recoverable from reinsurers is confirmed. Balances are included in the statutory statements of admitted assets, liabilities, and surplus and the statutory statements of operations, net of reinsurance, except for commissions and expense allowances on reinsurance ceded which are shown as income.

Amounts recoverable from reinsurers are based upon assumptions consistent with those used in establishing the liabilities related to the underlying reinsured contracts. Management believes the amounts recoverable are appropriately established.

Premiums due under reinsurance agreements are reported as negative uncollected premiums in the statutory statements of admitted assets, liabilities, and surplus. Experience refunds related to reinsurance are reported as reinsurance recoverables.

Federal Income Taxes — The provision for income taxes includes amounts paid and accrued. The Company is subject to income tax in the United States and several state jurisdictions. Significant judgments and estimates are required in the determination of the Company's income tax expense, DTAs, and deferred tax liabilities ("DTLs").

Deferred taxes are recognized to the extent there are differences between the statutory and tax bases of assets and liabilities by using enacted tax rates in effect for the year in which the differences are expected to reverse. The effect of a change in tax rates on DTAs and DTLs is recognized in surplus in the period that includes the enactment date. Deferred taxes are also recognized for carryforward items including net operating loss, capital loss, and charitable contributions. NAIC SAP requires that temporary differences and carryforward items be identified and measured. Deductible temporary differences and carryforward amounts that generate tax benefits when they reverse or are utilized are tax affected in determining the DTA. Taxable temporary differences include items that will generate tax expense when they reverse and are tax affected in determining the DTL.

In the determination of the amount of the DTA that can be recognized and admitted, the NAIC SAP requires that DTAs be limited to an amount that is expected to be realized in the future based on a qualitative analysis of the Company's temporary differences, past financial history, and future earnings projections. The net admitted DTA shall not exceed the excess of the adjusted gross DTA over the gross DTL. The adjusted gross DTA shall be admitted based upon two components: an amount that is limited to the lesser of future deductible temporary differences and carryforward amounts that are expected to be realized within three years from the reporting date, or 15% of adjusted capital and surplus (defined as capital and surplus net of the admitted DTA, electronic data processing equipment, and operating software) and the adjusted gross DTA in an amount equal to the DTL.

The Company records uncertain tax positions in accordance with NAIC SAP on the basis of a two-step process in which (1) it determines whether a tax loss contingency meets a more-likely-than-not threshold (a likelihood of more than 50%) on the basis of the technical merits of the position and (2) for those tax positions that meet the more-likely-than-not recognition threshold, the Company recognizes 100% of the tax loss contingency. The Company recognizes interest accrued related to uncertain tax positions and penalties as income tax expense. The liability for uncertain tax positions and the associated interest liability are included in current federal income tax payable in the statutory statements of admitted assets, liabilities, and surplus.

Asset Valuation Reserve and Interest Maintenance Reserve — The Company establishes certain reserves as promulgated by the NAIC. The AVR is determined by formula and is based on the Company's investments in bonds, preferred stocks, common stocks, mortgage loans, real estate, short-term investments, and other invested assets. This valuation reserve requires appropriation of surplus to provide for possible losses on these investments. Realized and unrealized capital gains (losses), other than those resulting from interest rate changes, are credited or charged to the AVR.

The IMR is used to defer realized capital gains (losses), net of tax, on sales of bonds and certain other investments that result from interest rate changes. These gains (losses) are then amortized into investment income over what would have been the remaining years to maturity of the underlying investments.

Premiums and Annuity Considerations and Related Commissions — Life premiums are recognized as income over the premium-paying period of the policies. Health and accident premiums are recognized as income over the terms of the policies. Annuity considerations are recognized as income when received. Considerations received on deposit-type funds, which do not contain any life contingencies, are recorded directly to the related liability. Commissions and other expenses related to the acquisition of policies are charged to operations as incurred.

Vulnerability Due to Certain Risks and Concentrations — The following is a description of the most significant risks facing life and health insurers and how the Company manages those risks:

Morbidity/mortality risk is the risk that experience is unfavorable compared to company assumptions due to errors in setting assumption, catastrophic risk (e.g. pandemic), volatility, and changes in trend. The Company mitigates these risks through reinsurance programs, adherence to strict underwriting guidelines, monitoring underwriting exceptions, and a formal assumption review and approval process.

Legal/regulatory risk is the risk that changes in the legal or regulatory environment in which an insurer operates will occur and create additional costs or expenses not anticipated by the insurer in pricing its products. The Company mitigates this risk by operating throughout the United States, thus reducing its exposure to any single jurisdiction, and by diversifying its products. The Company monitors economic and regulatory developments that have the potential to impact its business.

Interest rate risk is the risk that interest rates will change and cause a decrease in the value of an insurer's investments or cause changes in policyholder behavior resulting in changes in asset or liability cash flows. The Company mitigates this risk through various asset-liability management techniques, including duration matching and matching the maturity schedules of its assets with the expected payouts of its liabilities. To the extent that liabilities come due more quickly than assets mature, the Company may have to sell assets prior to maturity and recognize a gain or loss.

Credit risk is the risk that issuers of securities owned by the Company will default, or that other parties, including reinsurers who owe the Company money, will not pay. The Company has policies regarding the financial stability and credit standing of its counterparties. The Company attempts to limit its credit risk by dealing with creditworthy counterparties and obtaining collateral where appropriate.

Liquidity risk is the risk that a given security or asset cannot be traded quickly enough in the market to prevent a loss, generate cash to meet funding requirements, or make a required profit. The Company has established an appropriate liquidity risk management framework to evaluate current and future funding and liquidity requirements. Future liquidity requirements are projected on a regular basis as part of the financial planning process.

Fair Value — Financial assets and liabilities have been categorized into a three-level fair value hierarchy, based on the priority of the inputs to the respective valuation technique. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). An asset or liability's classification within the fair value hierarchy is based on the lowest level of significant input to its valuation. The input levels are as follows:

Level 1 — Fair value is based on unadjusted quoted prices in active markets that are accessible to the Company for identical assets or liabilities. These generally provide the most reliable evidence and are used to measure fair value whenever available.

Level 2 — Fair value is based on significant inputs that are observable for the asset or liability, either directly or indirectly, through corroboration with observable market data. Level 2 inputs include quoted market prices in active markets for similar assets and liabilities, quoted market prices in markets that are not active for identical or similar assets or liabilities, and other market observable inputs. Valuations are generally obtained from third party pricing services for identical or comparable assets or liabilities and validated or determined through use of valuation methodologies using observable market inputs.

Level 3 — Fair value is based on significant unobservable inputs for the asset or liability. These inputs reflect assumptions about what market participants would use in pricing the asset or liability. Prices are determined using valuation methodologies such as option pricing models, discounted cash flow models, and other similar techniques.

Other-Than-Temporary Declines in Fair Value — The Company regularly reviews its investment portfolio for factors that may indicate that a decline in fair value of an investment is other-than-temporary. Some factors considered in evaluating whether or not a decline in fair value is other-than-temporary include the Company's ability and intent to retain the investment for a period of time sufficient to allow for a recovery in value, the Company's intent to sell the investment at the reporting date, and the financial condition and prospects of the issuer.

The Company recognizes OTTI of bonds not backed by loans when it is either probable that the Company will not collect all amounts due according to the contractual terms of the bond in effect at the date of acquisition or when the Company has made a decision to sell the bond prior to its maturity at an amount below its amortized cost. When an OTTI is recognized, the bond is written down to fair value and the amount of the write down is recorded as a realized capital loss in the statutory statements of operations.

For loan-backed securities, OTTI is recognized when the fair value is less than the amortized cost basis and the Company has the intent to sell or lacks the intent and ability to retain the investment until recovery. When an OTTI is recognized because the Company has the intent to sell or lacks the intent and ability to retain the investment until recovery, the amortized cost basis of the loan-backed security is written down to the fair value and the amount of the write-down is recorded as a realized capital loss in the statutory statements of operations.

If the Company does not have the intent to sell and has the intent and ability to retain the investment until recovery, OTTI is recognized when the present value of future cash flows discounted at the security's effective interest rate is less than the amortized cost basis as of the balance sheet date. When an OTTI is recognized, the loan-backed security is written down to the discounted estimated future cash flows and is recorded as a realized capital loss in the statutory statements of operations.

The Company recognizes OTTI of stocks for declines in value that is other-than-temporary and reports those adjustments as a realized capital loss in the statutory statements of operations.

The Company recognizes OTTI of limited partnerships generally when the underlying GAAP equity of the partnership is less than 80% of amortized cost or the limited partnership reports realized capital losses on their statutory financial statements or shows other indicators of loss. When an OTTI is recognized, the limited partnership is written down to fair value and the amount of the impairment is recorded as a realized capital loss in the statutory statements of operations.

The Company performs a monthly analysis of the prices received from third parties to assess if the prices represent a reasonable estimate of fair value. This process involves quantitative and qualitative analysis and is overseen by investment and accounting professionals.

Subsequent Events — The Company has evaluated events subsequent to December 31, 2017 through April 19, 2018, the date these statutory financial statements were available to be issued.

Accounting Pronouncements — During 2016, the NAIC issued revisions to SSAP No. 51 *Life Contracts* and SSAP No. 54R *Individual and Group Accident and Health Contracts* that require life, annuity, and health policies issued on or after the implementation of principles-based reserving to use the *Valuation Manual*, which describes reserve valuation under principles-based reserving ("PBR"), following an entity's adoption of PBR. These changes were effective January 1, 2017, however reporting entities may delay implementation for up to three years. The Company intends to adopt PBR in 2020 and is evaluating the impact of this guidance on its statutory financial statements.

In March 2017, the NAIC issued revisions to SSAP No. 35R *Guaranty Fund and Other Assessments* to require entities to discount liabilities for guaranty funds and the related assets from insolvencies of entities that wrote long-term care contracts. See Note 12 for the impact on the statutory statements of admitted assets, liabilities, and surplus upon adoption of this guidance on January 1, 2017.

In February 2018, the NAIC issued guidance clarifying disclosures under SSAP 101 *Income Taxes* concerning changes in deferred tax items as of December 31, 2017 related to the Tax Cuts and Jobs Act of 2017 ("Act") by requiring a narrative disclosure of the change in deferred tax items caused by the tax rate change under the Act. See Note 6 for the required disclosures.

2. INVESTMENTS

Bonds — The carrying value and estimated fair value of investments in bonds, including loan-backed securities, by type, and redeemable preferred stocks, as of December 31, were as follows:

2017	Carrying Value	Gross Unrealized Capital Gains	Gross Unrealized Capital Losses	Estimated Fair Value
U.S. government	$ 86,765,094	$ 5,255,873	$ 548,928	$ 91,472,039
States, territories, and possessions	34,754,346	2,548,524	20,889	37,281,981
Special revenue	177,551,338	1,568,403	643,731	178,476,010
Hybrid	470,426	27,021	-	497,447
Foreign corporate	2,625,217,335	135,121,586	9,081,838	2,751,257,083
U.S. and Canadian corporate	8,133,997,805	509,262,568	22,542,732	8,620,717,641
SVO Identified Funds - ETFs	51,362,502	-	-	51,362,502
Commercial MBS	796,864,742	42,133,138	702,058	838,295,822
Residential MBS	900,156,304	36,867,979	9,472,546	927,551,737
Other ABS	2,091,297,750	31,891,731	5,459,670	2,117,729,811
Total bonds	14,898,437,642	764,676,823	48,472,392	15,614,642,073
Redeemable preferred stocks	31,800,000	1,985,571	-	33,785,571
Total	$ 14,930,237,642	$ 766,662,394	$ 48,472,392	$ 15,648,427,644

2016	Carrying Value	Gross Unrealized Capital Gains	Gross Unrealized Capital Losses	Estimated Fair Value
U.S. government	$ 89,268,195	$ 6,782,437	$ 281,848	$ 95,768,784
States, territories, and possessions	35,026,923	2,529,135	62,272	37,493,786
Special revenue	147,723,495	532,693	1,813,367	146,442,821
Hybrid	472,239	-	13,662	458,577
Foreign corporate	2,449,986,600	117,778,868	23,759,914	2,544,005,554
U.S. and Canadian corporate	7,259,646,965	316,857,449	105,578,585	7,470,925,829
Commercial MBS	856,054,248	44,307,849	2,864,925	897,497,172
Residential MBS	840,849,068	44,167,846	7,139,790	877,877,124
Other ABS	2,118,053,775	32,261,618	16,598,648	2,133,716,745
Total bonds	13,797,081,508	565,217,895	158,113,011	14,204,186,392
Redeemable preferred stocks	28,800,000	1,553,692	-	30,353,692
Total	$ 13,825,881,508	$ 566,771,587	$ 158,113,011	$ 14,234,540,084

Bonds with an NAIC designation of 6 of $1,137,805 and $50,467,418 as of December 31, 2017 and 2016, respectively, were carried at the lower of amortized cost or fair value.

The Company's bond portfolio was primarily comprised of investment grade securities. Based upon designations by the NAIC, investment grade bonds comprised 95.2% and 94.7% of the Company's total bond portfolio as of December 31, 2017 and 2016, respectively. A portion of the Commercial and Residential MBS portfolios is backed by collateral guaranteed or insured by a United States government agency. As of December 31, 2017 and 2016, 90.7% and 96.9%, respectively, of the Residential MBS portfolio was guaranteed by a government agency. As of December 31, 2017 and 2016, 53.3% and 56.8%, respectively, of the Commercial MBS portfolio was guaranteed by a government agency.

Information regarding the Company's investments in structured notes as of December 31, 2017, was as follows:

CUSIP	Actual Cost	Fair Value	Book/Adjusted Carrying Value	Mortgage-Referenced Security
38141GFA7	$ 5,012,500	$ 5,000,000	$ 5,005,634	No

Information regarding the Company's prepayment penalties and acceleration fees in structured notes as of December 31, 2017, was as follows:

	General Account	Separate Account
Number of CUSIPs	56	-
Aggregate amount of investment income	$ 14,556,040	$ -

The carrying value and estimated fair value of bonds and redeemable preferred stocks as of December 31, 2017, by contractual maturity, are shown below. Actual maturities may differ as a result of prepayments by the issuer. MBS and other ABS provide for periodic payments throughout their lives so they are listed in a separate category.

	Carrying Value	Estimated Fair Value
Due in one year or less	$ 356,686,004	$ 360,798,613
Due after one year through five years	2,322,170,580	2,416,482,889
Due after five years through ten years	2,480,600,473	2,601,958,578
Due after ten years	5,982,461,789	6,385,610,194
	11,141,918,846	11,764,850,274
MBS and other ABS	3,788,318,796	3,883,577,370
Total	$ 14,930,237,642	$ 15,648,427,644

Aging of unrealized capital losses on the Company's investments in bonds and redeemable preferred stocks as of December 31, was as follows:

	Less than One Year		One Year or More		Total	
2017	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses
U.S. government	$ 20,878,301	$ 196,486	$ 24,900,183	$ 352,442	$ 45,778,484	$ 548,928
States, territories, and possessions	6,590,367	20,889	-	-	6,590,367	20,889
Special revenue	123,076,350	643,731	-	-	123,076,350	643,731
Foreign corporate	178,457,769	3,225,663	162,691,637	5,856,175	341,149,406	9,081,838
U.S. and Canadian corporate	455,909,037	5,914,312	498,669,343	16,628,420	954,578,380	22,542,732
Commercial MBS	48,254,361	400,329	6,933,074	301,729	55,187,435	702,058
Residential MBS	263,720,541	3,442,676	196,014,132	6,029,870	459,734,673	9,472,546
Other ABS	435,646,741	2,942,630	152,894,263	2,517,040	588,541,004	5,459,670
Total	$ 1,532,533,467	$ 16,786,716	$ 1,042,102,632	$ 31,685,676	$ 2,574,636,099	$ 48,472,392

	Less than One Year		One Year or More		Total	
2016	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses
U.S. government	$ 45,774,158	$ 281,848	$ -	$ -	$ 45,774,158	$ 281,848
States, territories, and possessions	6,488,050	62,272	-	-	6,488,050	62,272
Special revenue	58,379,513	1,813,367	-	-	58,379,513	1,813,367
Hybrid	458,576	13,662	-	-	458,576	13,662
Foreign corporate	490,727,901	18,956,072	50,779,175	4,803,842	541,507,076	23,759,914
U.S. and Canadian corporate	2,063,745,084	89,748,506	205,914,676	15,830,079	2,269,659,760	105,578,585
Commercial MBS	56,012,658	1,633,176	51,513,348	1,231,749	107,526,006	2,864,925
Residential MBS	344,663,001	5,979,274	28,416,770	1,160,516	373,079,771	7,139,790
Other ABS	754,392,945	14,493,904	149,751,298	2,104,744	904,144,243	16,598,648
Total	$ 3,820,641,886	$ 132,982,081	$ 486,375,267	$ 25,130,930	$ 4,307,017,153	$ 158,113,011

As described in Note 1, the Company regularly reviews its investment portfolio for factors that may indicate that a decline in fair value of an investment is other-than-temporary. As of December 31, 2017, 143 securities were in an unrealized capital loss position one year or more with an average credit rating of A2 and were 92.6% investment grade. As of December 31, 2017, 267 securities were in an unrealized capital loss position less than one year with an average credit rating of A1 and were 94.5% investment grade.

Net realized capital losses for the years ended December 31, 2017 and 2016 include losses of $13,604,142 and $11,418,708, respectively, resulting from other-than-temporary declines in the fair value of bonds or changes in expected cash flows, and are not included in the table above.

Gross unrealized capital losses for MBS and other ABS as of December 31, 2017, by vintage, were as follows:

		Non-Agency				
	Agency	2014 and Prior	2015	2016	2017	Total
Commercial MBS	$ -	$ 149,967	$ 28,949	$ 523,142	$ -	$ 702,058
Residential MBS	115,337	4,579,273	1,734,851	2,363,762	679,323	9,472,546
Other ABS	5,459,670	-	-	-	-	5,459,670
	$ 5,575,007	$ 4,729,240	$ 1,763,800	$ 2,886,904	$ 679,323	$ 15,634,274

Within its investments in ABS in the home equity sector, the Company has an exposure to subprime and Alt-A mortgage loans, which it manages in several ways. The Company monitors its exposure level to ABS against its annual investment authorization level approved by the Board of Directors. Restrictions include exposure at the aggregate level to ABS, along with exposure to ratings classes, subsectors, issuers, and specific assets. The Company also continually tracks securities backed by subprime mortgage loans for factors including credit performance, rating agency actions, prepayment trends, and de-levering. Loans with trends that may indicate underperformance are monitored closely for any further deterioration that may result in action by the Company. The Company's subprime and Alt-A mortgage loans as of December 31, 2017 and 2016 have a carrying value of $2,173,293 and $5,862,316, respectively, and the fair value of these loans exceeded the cost basis as of December 31, 2017.

Proceeds from sales or disposals of bonds and stocks and the components of bond and stocks net capital gains (losses) for the years ended December 31, were as follows:

	2017	2016	2015
Proceeds from sales or disposals:			
Bonds	$ 575,410,591	$ 142,703,463	$ 99,745,778
Stocks	$ 9,826,036	$ 9,075,758	$ 3,413,577
Net realized capital gains (losses) on bonds and stocks:			
Bonds:			
Gross realized capital gains from sales or other disposals	$ 24,010,230	$ 2,590,532	$ 4,016,949
Gross realized capital losses from sales or other disposals	(2,386,794)	(4,692,675)	(2,562,614)
OTTI losses	(13,604,142)	(11,418,708)	(18,025,089)
Net realized capital gains (losses)	$ 8,019,294	$ (13,520,851)	$ (16,570,754)
Stocks:			
Gross realized capital gains from sales or other disposals	$ 2,689,073	$ 2,557,912	$ 932,231
Gross realized capital losses from sales or other disposals	(58,412)	(662)	-
Net realized capital gains	$ 2,630,661	$ 2,557,250	$ 932,231

Bond income due and accrued of $4,332,680 and $4,574,792 related to bonds in default was excluded from investment income during the years ended December 31, 2017 and 2016, respectively.

Preferred Stocks — The Company held perpetual preferred stocks invested in a single issuer with carrying amount and estimated fair value of $100,000,000 as of December 31, 2017, resulting in no unrealized capital loss positions. The Company did not hold any perpetual preferred stock as of December 31, 2016.

Common Stocks-Unaffiliated — Included within common stocks-unaffiliated as of December 31, 2017 and 2016 is FHLB capital stocks of $38,747,500 and $23,036,400, respectively. As of December 31, 2017 and 2016, $29,659,100 and $22,648,424, respectively, were classified as required stocks and the remaining $9,088,400 and $387,976, respectively, were classified as excess stocks.

Mortgage Loans — The Company invests in mortgage loans collateralized principally by commercial real estate throughout the United States. All of the Company's mortgage loans are managed as two classes and portfolio segments: commercial loans and farm loans. During 2017, the minimum and maximum lending rates for mortgage loans were 3.26% and 4.85%, respectively. The maximum percentage of any one loan to the value of the collateral security at the time of the loan, exclusive of insured, guaranteed or purchase money mortgages, acquired during 2017 was 70.6%. Mutual of Omaha and Companion participate in certain of the Company's mortgage loans.

Net realized capital losses for the years ended December 31, 2017, 2016, and 2015 include losses of $47,918, $431,803, and $535,919, respectively, resulting from impairments of mortgage loans.

Mortgage loan participations purchased from one loan originator comprise 24.6% and 32.3% of the portfolio as of December 31, 2017 and 2016, respectively. The properties collateralizing mortgage loans are geographically dispersed throughout the United States, with the largest concentration in California of approximately 18.1% and 19.4% of the portfolio as of December 31, 2017 and 2016, respectively.

The Company participates or is a co-lender in mortgage loan agreements with other lenders for farm and commercial mortgage loans. These amounts were $1,166,968,979 and $1,384,498,426 as of December 31, 2017 and 2016, respectively.

Credit Quality Indicators — For purposes of monitoring the credit quality and risk characteristics, the Company considers the current debt service coverage, loan to value ratios, leasing status, average rollover, loan performance, guarantees, and current rents in relation to current markets. The debt service coverage ratio compares a property's cash flow to amounts needed to service the principal and interest due under the loan. The credit quality indicators are updated annually or more frequently if conditions warrant based on the Company's credit monitoring process.

The Company's investment in mortgage loans, by credit quality profile, as of December 31, was as follows:

	Debt Service Coverage Ratios			
2017	**>1.20x**	**1.00x-1.20x**	**<1.00x**	**Total**
Loan-to-value ratios:				
Less than 65%	$1,679,108,605	$153,531,730	$ 69,353,932	$1,901,994,267
65% to 75%	170,993,946	39,369,663	1,516,810	211,880,419
76% to 80%	3,588,512	-	-	3,588,512
Greater than 80%	1,048,600	-	-	1,048,600
Total	$1,854,739,663	$192,901,393	$ 70,870,742	$2,118,511,798

	Debt Service Coverage Ratios			
2016	**>1.20x**	**1.00x-1.20x**	**<1.00x**	**Total**
Loan-to-value ratios:				
Less than 65%	$1,516,545,556	$174,614,013	$ 68,660,103	$1,759,819,672
65% to 75%	196,694,090	34,018,613	2,848,600	233,561,303
76% to 80%	644,300	884,571	518,844	2,047,715
Greater than 80%	2,881,638	1,852,986	-	4,734,624
Total	$1,716,765,584	$211,370,183	$ 72,027,547	$2,000,163,314

Non-Accrual and Past Due Loans — The Company's loans in current status were $2,117,892,172 and $1,998,202,711 as of December 31, 2017 and 2016, respectively. The Company's investment in loans that were 30–59 days past due were $619,626 and $1,135,847 as of December 31, 2017 and 2016, respectively. The Company had no loans that were 60-89 days past due as of December 31, 2017. The Company's investment in loans that were 60–89 days past due was $824,756 as of December 31, 2016. The Company had no loans that were 90–179 days or greater than 180 days past due as of December 31, 2017 and 2016. The recorded investment for loans where the interest rate was reduced was $39,926,679 and $31,092,714 as of December 31, 2017 and 2016, respectively. The number of loans impacted and the average interest rate reduction was 57 loans and 1.34%, respectively, for the year ended December 31, 2017. The number of loans impacted and the average interest rate reduction was 44 loans and 1.60%, respectively, for the year ended December 31, 2016.

The Company had no loans that were in non-accrual status as of December 31, 2017 and 2016.

Impaired Loans — Information related to impaired loans for the Company during 2017 and 2016, was as follows:

As of December 31,	**2017**	**2016**
Impaired mortgage loans	$ 8,513,026	$14,509,199
For the Years Ended December 31,	**2017**	**2016**
Average recorded investment	$12,001,136	$15,257,100
Interest income recognized	964,161	1,193,845
Interest received	976,254	1,205,568

The Company was not subject to a participant or co-lender mortgage loan agreement for which the Company is restricted from unilaterally foreclosing on the mortgage loan as of December 31, 2017 and 2016.

The Company had no allowance for credit losses as of December 31, 2017 and 2016.

Restructured Loans — The recorded investment in loans modified in a TDR were $7,933,488 and $10,073,476 during the years ended December 31, 2017 and 2016, respectively. The realized capital losses in a TDR were $79,003 for the year ended December 31, 2016. There were no realized capital losses in a TDR for the year ended December 31, 2017.

The Company had no TDRs as of December 31, 2017. During the year ended December 31, 2016, the Company modified two loans with a combined principal balance of $1,287,346 in a TDR. The Company did not have any mortgage loans that were restructured within the previous twelve months and subsequently defaulted on their restructured terms during the period. No additional funds were committed to debtors whose terms have been modified in the years ended December 31, 2017 and 2016.

Limited Partnerships — Net realized capital losses for the years ended December 31, 2017, 2016, and 2015 include losses of $5,475,171, $7,230,984, and $2,251,137, respectively, resulting from other-than-temporary declines in fair value of limited partnerships due to market conditions.

Restricted Assets — Information related to the Company's investment in restricted assets as of December 31, was as follows:

			Percentage	
2017	Gross Restricted Assets	Total Admitted Restricted Assets	Gross Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
Collateral held under security lending agreements	$ 287,498,568	$ 287,498,568	1.25 %	1.26 %
Letter stock or securities restricted as to sale-excluding FHLB capital stock	100,000,000	100,000,000	0.44	0.44
FHLB capital stocks	38,747,500	38,747,500	0.17	0.17
On deposit with states	5,459,539	5,459,539	0.02	0.02
Pledged collateral to FHLB (including assets backing funding agreements)	862,407,809	862,407,809	3.76	3.78
Pledged as collateral not captured in other categories	18,050,000	18,050,000	0.08	0.08
Total	$ 1,312,163,416	$ 1,312,163,416	5.72 %	5.75 %

			Percentage	
2016	Gross Restricted Assets	Total Admitted Restricted Assets	Gross Restricted to Total Assets	Admitted Restricted to Total Admitted Assets
Collateral held under security lending agreements	$ 154,808,895	$ 154,808,895	0.74 %	0.75 %
FHLB capital stocks	23,036,400	23,036,400	0.11	0.11
On deposit with states	5,218,194	5,218,194	0.03	0.03
Pledged collateral to FHLB (including assets backing funding agreements)	830,345,976	830,345,976	3.98	4.01
Total	$ 1,013,409,465	$ 1,013,409,465	4.86 %	4.90 %

Net Investment Income — The sources of net investment income for the years ended December 31, were as follows:

	2017	2016	2015
Bonds	$ 640,541,119	$ 595,473,734	$ 579,831,400
Preferred stocks	1,168,478	1,814,636	1,873,234
Mortgage loans	95,715,164	92,375,427	99,706,945
Real estate	15,078,888	15,923,714	16,295,891
Contract loans	11,913,709	12,056,284	12,264,684
Cash and cash equivalents	2,549,409	1,352,044	1,007,900
Short-term investments	184,866	1,153,980	1,286,783
Other	14,354,373	19,032,230	147,698,881
Gross investment income	781,506,006	739,182,049	859,965,718
Amortization of IMR	3,389,236	2,965,120	3,195,294
Investment expenses	(42,462,446)	(39,499,501)	(34,167,565)
Net investment income	$ 742,432,796	$ 702,647,668	$ 828,993,447

3. STRUCTURED SECURITIES

The carrying value and estimated fair value of structured securities, by type, as of December 31, were as follows:

2017	Carrying Value	Gross Unrealized Capital Gains	Gross Unrealized Capital Losses	Estimated Fair Value
MBS:				
Commercial	$ 796,864,742	$ 42,133,138	$ 702,058	$ 838,295,822
Residential	900,156,304	36,867,979	9,472,546	927,551,737
	1,697,021,046	79,001,117	10,174,604	1,765,847,559
Other ABS	2,091,297,750	31,891,731	5,459,670	2,117,729,811
Total	$ 3,788,318,796	$ 110,892,848	$ 15,634,274	$ 3,883,577,370

2016	Carrying Value	Gross Unrealized Capital Gains	Gross Unrealized Capital Losses	Estimated Fair Value
MBS:				
Commercial	$ 856,054,248	$ 44,307,849	$ 2,864,925	$ 897,497,172
Residential	840,849,068	44,167,846	7,139,790	877,877,124
	1,696,903,316	88,475,695	10,004,715	1,775,374,296
Other ABS	2,118,053,775	32,261,618	16,598,648	2,133,716,745
Total	$ 3,814,957,091	$ 120,737,313	$ 26,603,363	$ 3,909,091,041

Aging of unrealized capital losses on the Company's structured securities as of December 31, was as follows:

2017	Less than One Year		One Year or More		Total	
	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses
MBS:						
Commercial	$ 48,254,361	$ 400,329	$ 6,933,074	$ 301,729	$ 55,187,435	$ 702,058
Residential	263,720,541	3,442,676	196,014,132	6,029,870	459,734,673	9,472,546
	311,974,902	3,843,005	202,947,206	6,331,599	514,922,108	10,174,604
Other ABS	435,646,741	2,942,630	152,894,263	2,517,040	588,541,004	5,459,670
Total	$ 747,621,643	$ 6,785,635	$ 355,841,469	$ 8,848,639	$ 1,103,463,112	$ 15,634,274

2016	Less than One Year		One Year or More		Total	
	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses	Estimated Fair Value	Gross Unrealized Capital Losses
MBS:						
Commercial	$ 56,012,658	$ 1,633,176	$ 51,513,348	$ 1,231,749	$ 107,526,006	$ 2,864,925
Residential	344,663,001	5,979,274	28,416,770	1,160,516	373,079,771	7,139,790
	400,675,659	7,612,450	79,930,118	2,392,265	480,605,777	10,004,715
Other ABS	754,392,945	14,493,904	149,751,298	2,104,744	904,144,243	16,598,648
Total	$ 1,155,068,604	$ 22,106,354	$ 229,681,416	$ 4,497,009	$ 1,384,750,020	$ 26,603,363

OTTI is recognized based on the Company's intent to sell, inability to hold to maturity, and when the present value of future cash flows is expected to be less than the amortized cost of the security. There was no OTTI on loan-backed and structured securities related to the intent to sell or inability to hold to maturity during 2017 or 2016. All of the Company's OTTI on loan-backed and structured securities during 2017 and 2016 were based on the present value of future cash flows expected to be less than the amortized cost of the security as shown in the following tables:

2017	Amortized Cost Basis Before Current Period OTTI	Present Value of Projected Cash Flows	Recognized OTTI	Amortized Cost Basis After OTTI	Fair Value at the Date of Impairment	Date of Financial Statement Where Reported
CUSIP:						
46625MDB2	$ 39,668	$ -	$ 39,668	$ -	$ -	3/31/2017
524685AA2	21,040,415	19,828,312	1,212,103	19,828,312	18,360,135	3/31/2017
05952AAN4	2,130,738	1,479,950	650,788	1,479,950	1,337,997	6/30/2017
46630VAP7	1,040,378	629,860	410,518	629,860	5,768	6/30/2017
05952AAN4	1,478,197	1,431,252	46,944	1,431,252	1,165,177	9/30/2017
46630VAP7	643,884	-	643,884	-	-	9/30/2017
05952AAN4	1,144,768	573,169	571,599	573,169	276,405	12/31/2017
	$ 27,518,048	$ 23,942,543	$ 3,575,504	$ 23,942,543	$ 21,145,482	

2016	Amortized Cost Basis Before Current Period OTTI	Present Value of Projected Cash Flows	Recognized OTTI	Amortized Cost Basis After OTTI	Fair Value at the Date of Impairment	Date of Financial Statement Where Reported
CUSIP:						
46630VAP7	$ 512,662	$ 429,913	$ 82,750	$ 429,913	$ 24,976	3/31/2016
05952AAN4	2,125,830	2,096,163	29,667	2,096,163	2,096,163	5/31/2016
46625MDB2	546,154	115,599	430,555	115,599	30,000	6/30/2016
929766MZ3	915,860	905,705	10,155	905,705	815,385	6/30/2016
46625MDB2	117,553	81,720	35,833	81,720	720	9/30/2016
760985FR7	269,122	262,944	6,178	262,944	260,931	9/30/2016
929766MZ3	900,803	880,515	20,288	880,515	663,727	9/30/2016
929766NA7	97,753	90,005	7,748	90,005	40,025	9/30/2016
46625MDB2	82,216	39,031	43,186	39,031	360	12/31/2016
524685AA2	1,429,976	1,422,226	7,749	1,422,226	1,422,226	12/31/2016
929766NA7	87,939	-	87,939	-	-	12/31/2016
70469HAA7	1,163,403	851,142	312,261	851,142	634,442	12/31/2016
	$ 8,249,271	$ 7,174,963	$ 1,074,309	$ 7,174,963	$ 5,988,955	

4. FAIR VALUE MEASUREMENTS

The categorization of fair value measurements determined on a recurring basis, by input level, as of December 31, was as follows:

2017	Quoted Prices in Active Markets for Identical Assets or Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
State and political subdivisions securities	$ -	$ 87,803	$ -	$ 87,803
Commercial MBS	-	-	276,405	276,405
Other ABS	-	-	516,565	516,565
SVO Identified Funds - ETFs	51,362,502	-	-	51,362,502
Common stocks	9,211,219	38,747,500	-	47,958,719
Securities lending cash collateral	287,498,568	-	-	287,498,568
Derivative cash collateral	18,050,000	-	-	18,050,000
Derivative assets	341,244	20,257,680	-	20,598,924
Derivative liabilities	-	44,471,216	-	44,471,216
Total without separate accounts	366,463,533	103,564,199	792,970	470,820,702
Separate accounts	2,359,030,669	1,638,933,808	-	3,997,964,477
Total	$ 2,725,494,202	$ 1,742,498,007	$ 792,970	$ 4,468,785,179

2016	Quoted Prices in Active Markets for Identical Assets or Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
State and political subdivisions securities	$ -	$ 240,492	$ -	$ 240,492
U.S. and Canadian corporate securities	-	-	32,900,000	32,900,000
Foreign corporate securities	-	-	8,400,000	8,400,000
Other ABS	-	-	8,404,962	8,404,962
Common Stocks	-	23,036,400	-	23,036,400
Securities lending cash collateral	154,808,895	-	-	154,808,895
Derivative cash collateral	37,880,000	-	-	37,880,000
Derivative assets	-	41,213,191	-	41,213,191
Derivative liabilities	-	4,985,304	-	4,985,304
Total without separate accounts	192,688,895	69,475,387	49,704,962	311,869,244
Separate accounts	2,010,263,998	1,366,716,872	-	3,376,980,870
Total	$ 2,202,952,893	$ 1,436,192,259	$ 49,704,962	$ 3,688,850,114

Transfers between Levels 1 and 2 — Transfers in and/or out of any level are assumed to occur at the beginning of the period. During the year ended December 31, 2017 and 2016, there were no transfers between Level 1 and Level 2.

A description of the significant inputs and valuation techniques used to determine estimated fair value for assets and liabilities on a recurring basis is as follows:

Level 1 Measurements

SVO Identified Funds-ETFs and Common Stocks — These securities are principally valued using the market approach. The valuation of these securities is based principally on observable inputs including quoted prices in active markets.

Derivative Cash Collateral and Securities Lending Cash Collateral — Comprised of U.S. Direct Obligation/Full Faith and Credit Exempt money market instruments, commercial paper, cash, and all highly-liquid debt securities purchased with an original maturity of less than three months. These money market instruments are valued using unadjusted quoted prices in active markets that are accessible for identical assets and are primarily classified as Level 1. If public quotations are not available for commercial paper or debt securities, because of the highly liquid nature of these assets, carrying amounts may be used to approximate fair values. The carrying amount of cash approximates fair value.

Derivative Assets — These balances are comprised entirely of warrants and were valued using recent trade activity.

Separate Accounts — Separate accounts are comprised primarily of money market instruments, mutual funds, collective investment trusts, exchange trades funds, and common stock. Valuation is based on actively traded money market instruments, mutual funds, collective investment trusts, exchange trades funds, and common stocks that have daily quoted net asset values for identical assets that the Company can access.

Level 2 Measurements

State and Political Subdivisions Securities — These securities are principally valued using the market approach, which uses prices and other relevant information generated by market transactions for similar assets. The valuation of these securities is based primarily on quoted prices in active markets, or through the use of matrix pricing or other similar techniques using standard market observable inputs such as the benchmark U.S. Treasury yield curve, the spread from the U.S. Treasury curve for the identical security and comparable securities that are actively traded.

Common Stocks-Unaffiliated — These securities are only redeemable at par, so the fair value is presumed to be par.

Derivative Assets and Liabilities — These derivatives include swaptions, foreign currency swaps, and call spread options, and are principally valued using an income approach. Valuations are based on present value techniques and option pricing models, which utilize significant inputs that may include implied volatility, the swap yield curve, LIBOR basis curves, repurchase rates, currency spot rates, and cross currency basis curves.

Separate Accounts — Separate accounts are comprised primarily of common collective trusts which are valued based on independent pricing services and non-binding broker quotations. The pricing services, in general, employ a market approach to valuing portfolio investments using market prices from exchanges or matrix pricing when quoted prices are not available and other relevant data inputs as necessary. When current market prices or pricing service quotations are not available, the trustees use contractual cash flows and other inputs to value the funds.

Level 3 Measurements

In general, investments classified within Level 3 use many of the same valuation techniques and inputs as described above. However, if key inputs are unobservable, or if the investments are illiquid and there is very limited trading activity, the investments are generally classified as Level 3. The use of independent non-binding broker quotations to value investments generally indicates there is a lack of liquidity or the general lack of transparency to develop the valuation estimates, causing these investments to be classified in Level 3.

U.S. and Canadian Corporate and Foreign Corporate Securities — These securities are principally valued using the market and income approaches. Valuations of these securities are based primarily on matrix pricing or other similar techniques that utilize unobservable inputs or cannot be derived principally from, or corroborated by, observable market data, including illiquidity premiums and spread adjustments to reflect industry trends or specific credit-related issues. Valuations may be based on independent non-binding broker quotations. The use of independent non-binding broker quotations to value investments generally indicates there is a lack of liquidity or the general lack of transparency to develop the valuation estimates generally causing these investments to be classified in Level 3. Generally, below investment grade privately placed or distressed securities included in this level are valued using discounted cash flow methodologies which rely upon significant, unobservable inputs, and inputs that cannot be derived principally from, or corroborated by, observable market data.

Structured Securities comprised of Commercial MBS and Other ABS — These securities are principally valued using the market approach. The valuation of these securities is based primarily on matrix pricing or other similar techniques that utilize inputs that are unobservable or cannot be derived principally from, or corroborated by, observable market data, or are based on independent non-binding broker quotations.

Changes in assets and liabilities measured at fair value on a recurring basis using significant unobservable inputs (Level 3) during the years ended December 31, 2017 and 2016, were as follows:

	Balance January 1, 2017	Capital Gains (Losses) Included in Realized Capital Gains (Losses)	Capital Gains (Losses) Included in Surplus	Purchases	Sales and Repayments	Net Transfers Into Level 3	Net Transfers Out of Level 3	Balance December 31, 2017
U.S. and Canadian corporate securities	$ 32,900,000	$ -	$ 114,882	$ -	$ (33,014,882)	$ -	$ -	$ -
Foreign corporate services	8,400,000	-		-	(8,400,000)	-	-	-
Commercial MBS	-	(1,269,331)	(296,764)	-	(273,151)	2,115,651	-	276,405
Other ABS	8,404,962	-	(131,070)	-	(8,608,469)	851,142	-	516,565
Total	$ 49,704,962	$ (1,269,331)	$ (312,952)	$ -	$ (50,296,502)	$ 2,966,793	$ -	$ 792,970

	Balance January 1, 2016	Capital Gains (Losses) Included in Realized Capital Gains (Losses)	Capital Gains (Losses) Included in Surplus	Purchases	Sales and Repayments	Net Transfers Into Level 3	Net Transfers Out of Level 3	Balance December 31, 2016
U.S. and Canadian corporate securities	$ -	$ (3,600,000)	$ (114,882)	$ -	$ (34,085)	$ 36,648,967	$ -	$ 32,900,000
Foreign corporate services	-	(3,600,000)	-	-	-	12,000,000	-	8,400,000
Commercial MBS	26,775	(95,687)	21,567	-	47,345	-	-	-
Other ABS	1,551,451	-	(5,584)	-	(5,184,865)	12,043,960	-	8,404,962
Total	$ 1,578,226	$ (7,295,687)	$ (98,899)	$ -	$ (5,171,605)	$ 60,692,927	$ -	$ 49,704,962

Fair Value of Financial Instruments — The carrying values, estimated fair values, and the level within the fair value hierarchy in which the Company's financial instruments fall as of December 31, were as follows:

2017	Carrying Value	Estimated Fair Value	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Financial assets:						
Bonds	$ 14,898,437,642	$ 15,614,642,073	$ 51,362,502	$ 14,340,958,455	$ 1,222,321,116	$ -
Preferred stocks	131,800,000	133,785,571	-	33,785,571	-	100,000,000
Common stocks — unaffiliated	47,958,719	47,958,719	9,211,219	38,747,500	-	-
Mortgage loans	2,118,511,798	2,144,690,214	-	-	2,144,690,214	-
Contract loans	184,171,324	184,171,324	-	-	-	184,171,324
Cash and cash equivalents	(4,408,157)	(4,407,262)	(6,417,462)	2,010,200	-	-
Short-term investments	104,786,154	104,786,045	-	104,786,045	-	-
Securities lending cash collateral	287,498,568	287,498,568	287,498,568	-	-	-
Derivative assets	20,598,924	20,598,924	341,244	20,257,680	-	-
Financial liabilities:						
Deposit-type contracts	2,827,783,339	2,833,258,590	-	-	2,833,258,590	-
Securities lending cash collateral	287,498,568	287,498,568	287,498,568	-	-	-
Derivative cash collateral	1,010,000	1,010,000	1,010,000	-	-	-
Derivative liabilities	44,471,216	44,471,216	-	44,471,216	-	-
Borrowings	59,343,493	63,457,656	-	63,457,656	-	-

2016	Carrying Value	Estimated Fair Value	Level 1	Level 2	Level 3	Not Practicable (Carrying Value)
Financial assets:						
Bonds	$ 13,797,081,508	$ 14,204,186,392	$ -	$ 12,954,687,447	$ 1,249,498,944	$ -
Preferred stocks	28,800,000	30,353,692	-	30,353,692	-	-
Common stocks — unaffiliated	23,036,400	23,036,400	-	23,036,400	-	-
Mortgage loans	2,000,163,314	2,022,208,344	-	-	2,022,208,344	-
Contract loans	179,965,773	179,965,773	-	-	-	179,965,773
Cash and cash equivalents	51,472,241	51,472,241	51,472,241	-	-	-
Short-term investments	50,000,000	50,000,000	-	50,000,000	-	-
Securities lending cash collateral	154,808,895	154,808,895	154,808,895	-	-	-
Derivative assets	41,213,191	41,213,191	-	41,213,191	-	-
Financial liabilities:						
Deposit-type contracts	2,691,722,811	2,585,791,579	-	-	2,585,791,579	-
Securities lending cash collateral	154,808,895	154,808,895	154,808,895	-	-	-
Derivative cash collateral	37,880,000	37,880,000	37,880,000	-	-	-
Derivative liabilities	4,985,304	4,985,304	-	4,985,304	-	-
Borrowings	70,298,400	77,037,214	-	77,037,214	-	-

The following methods and assumptions were used by the Company in estimating its fair value disclosures for financial instruments:

The fair values of cash collateral, common stocks-unaffiliated, and derivative financial instruments are estimated as discussed above.

Bonds — The fair values for bonds, including loan-backed securities, are based on quoted market prices, where available. For bonds for which market values are not readily available, fair values were estimated by the Company using projected future cash flows, current market rates, credit quality, and maturity date.

Preferred Stocks — The fair values for preferred stocks are based on market value, where available. For preferred stocks for which market values are not available, fair values were estimated by the Company using projected future cash flows, current market rates, credit quality, and maturity date. It is not practicable to measure the value in certain private preferred stock and the carrying value approximates the fair value.

Mortgage Loans — The fair values for mortgage loans are estimated by discounting expected future cash flows using current interest rates for similar loans with similar credit risk.

Contract Loans — Contract loans are stated at the aggregate unpaid balance. It is not practicable to determine fair value as contract loans are often repaid by reducing the policy benefits and have variable maturity dates.

Cash and Cash Equivalents — The fair value for cash equivalents includes a bond with less than a year to maturity, are valued using a discounted cash flow methodology using standard market observable inputs, and inputs derived from, or corroborated by, market observable data, including the market yield curve, duration, call provisions, observable prices, and spreads for similar publicly traded issues that incorporate the credit quality and industry sector of the issuer. The carrying amount for cash and other cash equivalents approximates fair value.

Short-Term Investments — The fair values for short-term investments includes public bonds with less than a year to maturity, are valued using a discounted cash flow methodology using standard market observable inputs, and inputs derived from, or corroborated by, market observable data, including the market yield curve, duration, call provisions, observable prices, and spreads for similar publicly traded issues that incorporate the credit quality and industry sector of the issuer. The carrying amount for the other short-term investments approximates fair value.

Deposit-Type Contracts — The fair values of Guaranteed Interest Contracts, annuities, and supplementary contracts without life contingencies in payout status are estimated by calculating an average present value of expected cash flows over a broad range of interest rate scenarios using the current market risk-free interest rates adjusted for spreads required for publicly traded bonds issued by comparably rated insurers. The carrying amounts for all other deposit-type contracts approximates their fair value.

Borrowings — The fair values of long-term FHLB borrowings are estimated by discounting expected future cash flows using current interest rates for debt with comparable terms. The fair values of other borrowings are deemed to be the same as its carrying value.

5. DERIVATIVE FINANCIAL INSTRUMENTS

The following tables summarize the Company's derivative financial instruments as of December 31:

2017	Contracts	Notional Amount	Credit Exposure	Carrying Value		Estimated Fair Value	
				Assets	Liabilities	Assets	Liabilities
Foreign currency swap	N/A	$ 688,809,975	$ 10,978,713	$ 17,667,187	$ 44,445,870	$ 17,667,187	$ 44,445,870
Call spread options	N/A	33,131,897	-	2,590,492	25,346	2,590,492	25,346
Warrants	14,338	N/A	-	341,245	-	341,245	-
Total	14,338	$ 721,941,872	$ 10,978,713	$ 20,598,924	$ 44,471,216	$ 20,598,924	$ 44,471,216

2016	Contracts	Notional Amount	Credit Exposure	Carrying Value		Estimated Fair Value	
				Assets	Liabilities	Assets	Liabilities
Foreign currency swap	N/A	$ 431,375,297	$ 6,771,783	$ 40,606,731	$ 4,985,304	$ 40,606,731	$ 4,985,304
Swaptions	N/A	1,650,000,000	3,761,481	-	-	-	-
Call spread options	N/A	9,762,310	-	606,460	-	606,460	-
Total	N/A	$ 2,091,137,607	$ 10,533,264	$ 41,213,191	$ 4,985,304	$ 41,213,191	$ 4,985,304

The following changes in value of derivatives for the years ended December 31, were reported in the statutory financial statements as follows:

2017	Unassigned Surplus	Net Realized Capital Losses	Net Investment Income
Foreign currency swaps	$ (62,400,110)	$ 403,937	$ 5,899,395
Swaptions	3,444,375	(3,444,375)	-
Call spread options	940,642	766,678	-
Total	$ (58,015,093)	$ (2,273,760)	$ 5,899,395

2016	Unassigned Surplus	Net Realized Capital Losses	Net Investment Income
Interest-rate swaps	$ 674,166	$ (324,000)	$ (427,744)
Foreign currency swaps	8,708,002	1,448,487	3,539,998
Swaptions	6,875,000	(6,875,000)	-
Call spread options	126,419	-	-
Total	$ 16,383,587	$ (5,750,513)	$ 3,112,254

2015	Unassigned Surplus	Net Realized Capital Losses	Net Investment Income
Interest-rate swaps	$ 665,005	$ -	$ (916,292)
Foreign currency swaps	17,528,787	-	2,085,462
Swaptions	1,545,185	(3,052,500)	-
Total	$ 19,738,977	$ (3,052,500)	$ 1,169,170

Certain of the Company's derivative instruments contain provisions requiring collateral against the fair value subject to minimum transfer amounts. The aggregate fair value of all the derivative instruments with collateral features was a liability of $24,213,536 and an asset of $35,836,545 on December 31, 2017 and 2016, respectively. The Company pledged $18,050,000 of cash collateral as of December 31, 2017. There was no cash collateral pledged by the Company as of December 31, 2016. The Company was holding $1,010,000 and $37,880,000 of cash collateral as of December 31, 2017 and 2016, respectively.

6. INCOME TAXES

The Company's federal income tax return is consolidated with the following entities: Mutual of Omaha, Companion, United World Life, Property and Casualty Company of Omaha, Omaha Re, Mutual of Omaha Structured Settlement Company, Mutual of Omaha Holdings, Inc. and its subsidiaries, Omaha Financial Holdings, Inc. and its subsidiaries, Mutual of Omaha Medicare Advantage Company, and The Omaha Indemnity Company. The Company also files state income tax returns in various jurisdictions.

Income taxes are allocated among the companies pursuant to a written agreement approved by the Board of Directors. Each company's provision for federal income taxes is based on separate return calculations with credit for net operating losses and capital losses allowed only as each company would utilize such losses on a separate return basis with limited exceptions.

On December 22, 2017, the Act was signed into law. The Act included numerous changes, including a permanent reduction in the federal corporate income tax rate from 35% to 21%, effective January 1, 2018. As a result of the reduction in rates, the deferred tax asset was reduced, which resulted in a decrease of $101,821,330 to surplus for the year ended December 31, 2017. See the effective tax rate reconciliation table below for details of this adjustment.

In the event of future tax losses, such losses cannot be carried back to prior years, but carry forward indefinitely where such carry forward is limited to a deduction equal to 80% of the taxable income in any one year.

The Company's DTL does not include a DTL for the unrealized capital gains (losses) for its investment in subsidiaries.

There were no deposits admitted under Section 6603 of the Internal Revenue Code.

Federal income taxes incurred for the years ended December 31, consisted of the following major components:

	2017	2016	2015
Current federal income tax expense	$ 42,992,987	$ 23,519,700	$ 38,208,236
Current foreign income tax expense	130,234	50,207	65,208
Federal income tax expense	43,123,221	23,569,907	38,273,444
Federal income tax expense (benefit) on net realized capital losses	3,961,385	(1,212,222)	1,468,554
Total federal and foreign income tax expense	47,084,606	22,357,685	39,741,998
Change in net deferred income taxes	73,181,690	8,860,779	3,344,152
Total federal income tax expense incurred	$ 120,266,296	$ 31,218,464	$ 43,086,150

Reconciliations between income taxes based on the federal tax rate and the effective tax rate for the years ended December 31, were as follows:

	2017	2016	2015
Net gain from operations before federal income taxes and net realized capital losses	$ 116,698,754	$ 32,648,909	$ 215,630,167
Net realized capital gains (losses) before federal income taxes and transfers to IMR	3,546,061	(1,983,843)	(20,846,506)
Total pre-tax gain	120,244,815	30,665,066	194,783,661
Statutory tax rate	35 %	35 %	35 %
Expected federal income taxes incurred	42,085,686	10,732,773	68,174,281
Affiliate reinsurance reserve transfer	9,270	33,202,358	152,138
Prior year tax benefits	(3,415,267)	(1,201,315)	-
Dividends received deduction	(1,153,030)	(1,329,025)	(1,443,314)
Amortization of IMR	(1,186,233)	(1,037,792)	(1,118,353)
Change in nonadmitted assets	(6,793,528)	(4,461,228)	(3,057,351)
Reserve changes in surplus	(6,744,074)	(3,879,836)	(18,614,899)
Other	(4,357,858)	(807,471)	(1,006,352)
Federal income tax expense at effective rate before 2017 tax legislation	18,444,966	31,218,464	43,086,150
Impact of 2017 tax legislation	101,821,330	-	-
Total federal income tax expense at effective tax rate after 2017 tax legislation	$ 120,266,296	$ 31,218,464	$ 43,086,150

The statute of limitations has closed on all years through 2013. Therefore, the years after 2013 remain subject to audit by federal and state tax jurisdictions.

There were no net operating loss carryforwards as of December 31, 2017.

For the years ended December 31, 2017 and 2016, there was no income tax accrual for uncertain tax positions. As of December 31, 2017, there were no positions for which management believes it is reasonably possible that the total amounts of tax contingencies will significantly increase within 12 months of the reporting date. As of December 31, 2017 and 2016, the Company had no statutory valuation allowance reducing its DTA.

The components of DTA and DTL as of December 31, were as follows:

	2017		
	Ordinary	Capital	Total
Gross DTA	$ 317,901,849	$ 6,750,462	$ 324,652,311
Nonadmitted DTA	(61,927,211)	-	(61,927,211)
Net admitted DTA	255,974,638	6,750,462	262,725,100
DTL	(165,169,851)	(6,750,462)	(171,920,313)
Net DTA	$ 90,804,787	$ -	$ 90,804,787

	2016		
	Ordinary	Capital	Total
Gross DTA	$ 334,364,478	$ 23,268,310	$ 357,632,788
Nonadmitted DTA	(93,135,365)	-	(93,135,365)
Net admitted DTA	241,229,113	23,268,310	264,497,423
DTL	(106,615,173)	(23,268,310)	(129,883,483)
Net DTA	$ 134,613,940	$ -	$ 134,613,940

In the calculation of the net admitted DTA, the capital DTL noted above is limited to the gross capital DTA. The excess of the capital DTL over the capital DTA has been reclassified to ordinary DTL in accordance with SSAP 101, paragraph 11.c.

The Company has admitted DTAs as of December 31, as follows:

	2017		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ -	$ -	$ -
Adjusted gross DTA expected to be realized (lesser of 1 or 2)	89,499,790	1,304,997	90,804,787
1. Adjusted gross DTA expected to be realized following the balance sheet date	89,499,790	1,304,997	90,804,787
2. Adjusted gross DTA allowed per limitation threshold	227,230,921	-	227,230,921
Adjusted gross DTA that can be offset against DTL	166,474,848	5,445,465	171,920,313
DTA admitted as the result of application of SSAP 101	$255,974,638	$ 6,750,462	$262,725,100

	2016		
	Ordinary	Capital	Total
Federal income taxes paid in prior years recoverable through loss carrybacks	$ 56,752,076	$ 4,987,425	$ 61,739,501
Adjusted gross DTA expected to be realized (lesser of 1 or 2)	72,874,439	-	72,874,439
1. Adjusted gross DTA expected to be realized following the balance sheet date	72,874,439	-	72,874,439
2. Adjusted gross DTA allowed per limitation threshold	194,222,477	-	194,222,477
Adjusted gross DTA that can be offset against DTL	111,602,598	18,280,885	129,883,483
DTA admitted as the result of application of SSAP 101	$241,229,113	$23,268,310	$264,497,423

The authorized control level risk-based capital ("RBC") ratio percentages used to determine recovery period and threshold limitation amounts were 840% and 809% as of December 31, 2017 and 2016, respectively. The amounts of adjusted capital and surplus used to determine recovery period and threshold limitations were $1,667,687,639 and $1,424,916,972 as of December 31, 2017 and 2016, respectively.

The Company has not utilized an income tax planning strategy for the realization of the DTA for 2017 and 2016.

The tax effects of temporary differences that give rise to significant portions of the DTA and DTL as of December 31, were as follows:

	2017	2016	Change
DTA:			
Ordinary:			
Policy reserves	$ 169,477,505	$ 109,381,253	$ 60,096,252
Investments	45,132	1,326,627	(1,281,495)
Deferred acquisition costs	125,345,514	196,323,644	(70,978,130)
Compensation and benefit accrual	5,858,959	9,545,286	(3,686,327)
Other expense accruals	3,036,011	817,251	2,218,760
Receivables — nonadmitted	748,916	1,922,486	(1,173,570)
Other nonadmitted assets	12,829,032	13,913,899	(1,084,867)
Other	560,780	1,134,032	(573,252)
Subtotal	317,901,849	334,364,478	(16,462,629)
Nonadmitted DTA	(61,927,211)	(93,135,365)	31,208,154
Admitted ordinary DTA	255,974,638	241,229,113	14,745,525
Capital:			
Investments	6,750,462	23,268,310	(16,517,848)
Admitted capital DTA	6,750,462	23,268,310	(16,517,848)
Admitted DTA	262,725,100	264,497,423	(1,772,323)
DTL:			
Ordinary:			
Investments	(6,615,592)	(24,112,728)	17,497,136
Fixed assets	(6,472,281)	(11,156,963)	4,684,682
Reserve basis adjustment	(114,131,661)	(29,261,822)	(84,869,839)
Advance commissions	(9,265,998)	(12,114,906)	2,848,908
Other	(2,899,783)	(4,568,935)	1,669,152
Subtotal	(139,385,315)	(81,215,354)	(58,169,961)
Capital:			
Investments	(31,578,189)	(47,073,447)	15,495,258
Real estate	(956,809)	(1,594,682)	637,873
Subtotal	(32,534,998)	(48,668,129)	16,133,131
DTL	(171,920,313)	(129,883,483)	(42,036,830)
Net admitted DTA	$ 90,804,787	$ 134,613,940	$ (43,809,153)

The change in net deferred income taxes, exclusive of nonadmitted assets reported separately in surplus in the annual statement, during the years ended December 31, was comprised of the following:

	2017	2016	Change
DTA	$324,652,311	$357,632,788	$(32,980,477)
DTL	(171,920,313)	(129,883,483)	(42,036,830)
Net DTA	$152,731,998	$227,749,305	(75,017,307)
Tax effect of unrealized capital gains			1,835,617
Change in net deferred income taxes			$(73,181,690)

	2016	2015	Change
DTA	$357,632,788	$347,463,749	$ 10,169,039
DTL	(129,883,483)	(120,264,735)	(9,618,748)
Net DTA	$227,749,305	$227,199,014	550,291
Tax effect of unrealized capital losses			(9,411,070)
Change in net deferred income taxes			$ (8,860,779)

7. RELATED PARTY INFORMATION

The Company's investments in non-insurance Subsidiary, Controlled, or Affiliated entities' ("SCAs"), as of December 31, were as follows:

	Admitted	Nonadmitted	Admitted	Nonadmitted
Fulcrum Growth Partners, L.L.C.	$ 1,401,185	$ -	$ 4,128,525	$ -
Fulcrum Growth Partners III, L.L.C.	58,134,725	-	56,148,893	-
UM Holdings, L.L.C.	-	166,302	-	30,648
Earnest SLR Trust	37,914,030	1,948,477	-	-
Legacy Benefits Ins Settlement	18,672,413	-	-	-

The audited statutory surplus of the Company's wholly owned insurance SCA, Omaha Re, reflects a departure from NAIC SAP for a prescribed practice from the NDOI, which requires an excess of loss asset be recorded as an admitted asset. The Company, however, has adjusted the investment in Omaha Re to be consistent with NAIC SAP, which does not allow the excess of loss asset to be an admitted asset.

The Company has an investment in an insurance SCA, Companion, for which the audited statutory surplus and income reflects a departure from NAIC SAP. Companion is domiciled in the State of New York and is required to record assets and liabilities under state law, if different from NAIC SAP. In 2017, this increased net income by $14,021,022 and decreased surplus $13,754,140. In 2016, this increased net income by $842,573 and decreased surplus $27,775,162. The differences primarily relate to reserve valuations under New York Regulation 147. The Company's investment in Companion was $57,412,745 and $47,893,084 at December 31, 2017 and 2016, respectively. The investment would have been $71,166,885 and $75,668,246 at December 2017 and 2016, respectively, without the prescribed practices. The RBC of Companion would not have triggered a regulatory event if the prescribed practice was not used.

During 2015, mortgage loan and real estate transfers between the Company and UM Holdings, L.L.C., were at fair value. The Company had no recorded losses on the transfer of real estate to UM Holdings L.L.C. The Company's contributions to and distributions from UM Holdings L.L.C. in 2015 were as follows:

	Cash	Mortgage Loans	Total
Contributions:			
May 11, 2015	$ -	$ 221,468	$ 221,468
Distributions:			
May 14, 2015	$ 150,000	$ -	$ 150,000
May 29, 2015	-	221,468	221,468
December 21, 2015	110,000	-	110,000
	$ 260,000	$ 221,468	$ 481,468

The Company has reinsurance agreements with affiliate entities. The Company assumes certain group and individual life insurance from Companion. The Company cedes certain individual life insurance to Omaha Re. The Company cedes certain individual health insurance to Mutual of Omaha. See Note 9 for impacts on the statutory financial statements due to these agreements.

The Company has a bilateral unsecured internal borrowing agreement with Mutual of Omaha that renews annually and allows Mutual of Omaha to borrow up to $250,000,000 from the Company. The interest rate for borrowing under this agreement in 2017 was from 0.75% to 1.50% and 0.45% during 2016. The amount outstanding as of December 31, 2017 was $96,000,000 and was included in short-term investments. The amount outstanding as of December 31, 2016 was $50,000,000 and was included in short-term investments. The Company received interest payments of $181,651 and $130,890 for the years ended December 31, 2017 and 2016, respectively. No interest payments were received for the years ended December 31, 2015.

The Company previously entered into a line of credit agreement with Omaha Financial Holdings, Inc. ("OFHI") at an interest rate of 2.45% and allowed OFHI to borrow up to $100,000,000 less any outstanding balances on promissory notes from the Company. On September 22, 2015, the line of credit matured and was not renewed. The Company received interest payments of $825,105 for the year ended December 31, 2015.

On June 21, 2017, a cash return of capital of $5,000,000 was made to the Company by Omaha Re.

On August 21, 2017, a cash return of capital of $6,500,000 was made to the Company by Omaha Re.

On December 22, 2017, the Company made a cash capital contribution of $5,000,000 to Omaha Re.

On December 27, 2017, a cash return of capital of $46,423,966 was made to the Company by Omaha Re.

On December 27, 2017, a securities and related interest return of capital of $81,381,102 was made to the Company by Omaha Re.

The Company recorded a capital contribution of $27,000,000 as a payable to Companion as of December 31, 2017, which was settled with cash on February 15, 2018.

On January 19, 2016, the Company made a cash capital contribution of $5,000,000 to Companion, which was accrued on December 31, 2015.

On April 1, 2016, the Company paid a dividend of $96,893,320 to Mutual of Omaha in the form of a transferred private equity investment.

On December 27, 2016, the Company made a cash capital contribution of $5,000,000 to Omaha Re.

On December 29, 2016, a cash return of capital of $24,000,000 was made to the Company by Omaha Re.

On September 4, 2015, the Company made a cash capital contribution of $1,000,000 to Omaha Life Insurance Company.

On September 28, 2015, a cash return of capital of $1,000,000 was made to the Company by Omaha Life Insurance Company.

On December 30, 2015, the Company made a cash capital contribution of $10,000,000 to Companion.

The Company is a member of a controlled group of companies and as such, its results may not be indicative of those if it were to be operated on a stand-alone basis. Any amounts due to or from each affiliated company are presented on a net basis in the statutory financial statements.

Mutual of Omaha and certain of its direct and indirect subsidiaries, including the Company, share certain resources such as personnel, operational and administrative services, facilities, information and communication services, employee benefits administration, investment management, advertising, and general management services. Most of the expenses related to these resources were paid by Mutual of Omaha and are subject to allocation among Mutual of Omaha and its subsidiaries. Management believes the measures used to allocate expenses among companies provide a reasonable allocation that conforms to NAIC guidelines. Additionally, certain amounts are paid or collected by Mutual of Omaha on behalf of the Company and are generally settled within 30 days. Amounts due to the parent from the Company for these services were included in payable to parent, subsidiaries, and affiliates and were $66,785,947 and $75,160,231 as of December 31, 2017 and 2016, respectively.

8. BORROWINGS

A summary of the Company's borrowings outstanding as of December 31, 2017, was as follows:

FHLB advances due in 2023 at 5.03% interest rate	$ 59,343,493
Securities lending	287,498,568
	$ 346,842,061

The Company has a borrowing agreement with the FHLB under which the Company pledges bonds in return for extensions of credit. The Company and Mutual of Omaha have jointly authorized a maximum extension of credit with the FHLB of $1,000,000,000 with a maximum of $600,000,000 available for funding agreement contracts. The maximum amount borrowed by the Company under this agreement, excluding funding agreement contracts, was $249,272,722 during the year ended December 31, 2017. The Company held $3,473,913 and $2,406,788 of FHLB stocks as part of this borrowing agreement as of December 31, 2017 and 2016, respectively.

The liability for the funding agreements was $600,000,000 as of December 31, 2017 and 2016, and was included in deposit-type contracts. As of December 31, 2017, the related accrued interest was $731,272 and is due in 2018. The related accrued interest as of December 31, 2016 was $330,863 and was due in 2017. The Company held $35,273,587 and $20,629,612 of FHLB stocks as part of these contracts as of December 31, 2017 and 2016, respectively.

As of December 31, 2017, the funding agreement contracts mature as follows:

2018	$235,000,000
2019	167,000,000
2020	105,000,000
2021	93,000,000
	$600,000,000

The Company had MBS pledged as collateral with carrying values of $862,407,809 and $830,345,976, respectively, and with fair values of $894,612,391 and $868,666,303 pledged under these agreements as of December 31, 2017 and 2016, respectively.

The Company had securities loaned to third parties of $387,190,944 and $159,831,672 as of December 31, 2017 and 2016, respectively. The Company received cash collateral of $287,498,568 and $154,808,895 through these security lending agreements as of December 31, 2017 and 2016, respectively, and is reported as a liability for funds held for securities on loan included in borrowings on the statutory statements of admitted assets, liabilities, and surplus. The securities loaned as of December 31, 2017 and 2016 were on open terms whereby the related loaned security could be returned to the Company on the next business day requiring return of cash collateral. The Company cannot access the cash collateral unless the borrower fails to deliver the loaned securities.

The amortized cost and estimated fair values of the Company's collateral as of December 31, 2017, were as follows:

30 days or less	$ 95,550,539
31 to 60 days	63,951,101
61 to 90 days	50,183,954
91 to 120 days	24,316,554
121 to 180 days	34,043,176
181 to 365 days	19,453,244
Total collateral received	$ 287,498,568

The Company and Mutual of Omaha, on a joint basis, have entered into certain unsecured revolving line of credit agreements that allow for maximum borrowings of $150,000,000 and are renewed annually. As of December 31, 2017 and 2016, the Company had no outstanding borrowings under these agreements. Interest expense of $6,464, $478, and $112 was incurred for the years ended December 31, 2017 2016, and 2015, respectively.

The Company and Mutual of Omaha, have bilateral unsecured internal borrowing agreements for $250,000,000 as of December 31, 2017 and 2016. As of December 31, 2017 and 2016, the Company had no outstanding borrowings under these agreements. Interest expense of $367,038 and $6,368 was incurred for the years ended December 31, 2017 and 2015, respectively. No interest expense was incurred for the year ended December 31, 2016.

The Company has an agreement to sell and repurchase securities. Under this agreement, the Company obtains the use of funds for a period not to exceed 30 days. Maximum borrowings allowed under this agreement is $500,000,000. The Company had no outstanding borrowings under this agreement as of December 31, 2017 and 2016. Interest expense of $46,466, $21, and $626 was incurred for the years ended December 31, 2017, 2016, and 2015, respectively.

9. REINSURANCE

Amounts recoverable from reinsurers are estimated based upon assumptions consistent with those used in establishing the liabilities related to the underlying reinsured contracts. Management believes the recoverables are appropriately established.

The Company has a reinsurance agreement with Omaha Re executed in 2012 with certain amendments executed in the years 2014 through 2017 to allow for additional life insurance policies to be part of the agreement or to change certain other terms and conditions. This agreement cedes certain term and universal life policies issued from January 1, 2003 through September 30, 2013 to Omaha Re. A new reinsurance agreement with Omaha Re was executed in 2016 and amended in 2017 which cedes added certain term life insurance policies issued from October 1, 2013 through December 31, 2017. The 2017 amendment allows for policies issued through December 31, 2019 to be ceded subject to certain limits. Both agreements provide coinsurance to the Company on an indemnity basis for all liabilities arising from the life insurance policies covered under each agreement and are accounted for on a funds withheld basis.

The current agreement was modeled under NAIC Actuarial Guideline XLVIII ("AG48"). This agreement cedes policies that meet the definition of Covered Policies as that term is defined in Section 4 of AG48. Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by the Company on a funds withheld basis. Funds consisting of Other Security, in an amount equal to the portion of the statutory reserves as to which Primary Security is not held, are held on behalf of the Company as security as part of the reinsurance arrangement.

The Company's significant financial impacts of the reinsurance arrangement with Omaha Re for the years ended December 31, were as follows:

	2017	2016	2015
Statutory statements of operations:			
Net premium considerations	$ 4,341,942	$ 205,649,999	$ 13,838,072
Increase in reserves	4,341,942	239,656,539	940,271
Statutory statements of admitted assets, liabilities, and surplus:			
Reserves for life policies and contracts	$ 4,341,942	$ 239,656,539	$ 13,838,072
Funds held under coinsurance increase	123,006,964	57,806,891	13,403,393
Deferred gain reflected in unassigned surplus	127,369,906	119,664,966	434,679

Deferred gains are amortized into operations as earnings emerge from the business reinsured. During 2017, 2016, and 2015, the Company amortized $30,017,000, $9,335,161, and $4,275,835, respectively, into other income.

A summary of the impact of reinsurance operations on the statutory statements of operations for the years ended December 31, was as follows:

	2017	2016	2015
Premium considerations:			
Assumed:			
Affiliates	$ 29,188,457	$ 28,275,660	$ 27,360,025
Non-affiliates	313,795	251,394	432,138
	$ 29,502,252	$ 28,527,054	$ 27,792,163
Ceded:			
Affiliates	$506,783,451	$600,313,247	$353,308,611
Non-affiliates	318,378,426	166,839,018	126,081,773
	$825,161,877	$767,152,265	$479,390,384
Commissions and expense allowances on reinsurance ceded:			
Affiliates	$107,237,758	$ 85,538,596	$ 69,853,575
Non-affiliates	42,779,763	21,439,482	16,939,376
	$150,017,521	$106,978,078	$ 86,792,951
Policyholder benefits:			
Assumed:			
Affiliates	$ 21,465,374	$ 16,919,675	$ 16,940,877
Non-affiliates	1,962,291	1,541,418	77,447
	$ 23,427,665	$ 18,461,093	$ 17,018,324
Ceded:			
Affiliates	$259,034,823	$224,231,502	$191,450,096
Non-affiliates	310,790,274	203,872,386	112,573,925
	$569,825,097	$428,103,888	$304,024,021
Operating expenses (including change in loading):			
Ceded:			
Affiliates	$ 16,727,781	$ 39,863,778	$ 3,405,770

A summary of the impact of reinsurance operations on the statements of admitted assets, liabilities, and surplus as of December 31, was as follows:

	2017	2016
Reserves for policies and contracts:		
Assumed:		
Affiliates	$ 30,575,573	$ 29,954,443
Non-affiliates	778,642	846,747
	$ 31,354,215	$ 30,801,190
Ceded:		
Affiliates	$ 2,393,447,596	$ 2,123,184,348
Non-affiliates	353,983,234	343,664,530
	$ 2,747,430,830	$ 2,466,848,878
Policy and contract claims:		
Assumed:		
Affiliates	$ 4,257,506	$ 3,007,418
Ceded:		
Affiliates	$ 52,211,924	$ 43,938,624
Non-affiliates	84,191,218	83,912,374
	$ 136,403,142	$ 127,850,998
Premiums deferred and uncollected:		
Ceded:		
Affiliates	$ 177,336,301	$ 153,691,286
Non-affiliates	93,088,150	88,752,784
	$ 270,424,451	$ 242,444,070
Funds held under reinsurance treaties included in reinsurance recoverable (all related party)	$ 47,711,040	$ 42,553,414
Funds held under reinsurance treaties included in funds held under coinsurance (all related party)	$ 1,114,811,241	$ 1,107,118,053

10. EMPLOYEE BENEFIT PLANS

The Company participates in three plans sponsored by its parent, Mutual of Omaha. These plans are a qualified, non-contributory defined benefit pension plan, a 401(k) defined contribution plan, and a postretirement benefit plan that provides certain health care and life insurance benefits to retired employees. Effective January 1, 2005, the defined benefit pension plan was amended to freeze plan benefits for participants under 40 years of age. No benefits are available under the defined benefit pension plan for employees hired on or after January 1, 2005. Substantially, all employees are eligible for the 401(k) Plan, while only employees hired before 1995 are eligible for the postretirement benefit plan. The Company has no legal obligation for benefits under these plans. Mutual of Omaha allocates expense amounts for these plans to the Company based on various cost allocation methods.

The Company's share of net expense for these plans for the years ended December 31, was as follows:

	2017	2016	2015
Defined benefit pension plan	$ 14,009,810	$ 17,172,668	$ 16,074,503
401(k) defined contribution plan	15,912,697	11,484,563	9,439,727
Postretirement benefit plan	641,215	2,542,642	2,576,182

Plan assets for the defined benefit pension plan included a group annuity contract issued by the Company with a balance of $635,311,213 and $627,181,325 as of December 31, 2017 and 2016, respectively. Plan assets for the postretirement benefit plan were invested in a group annuity contract issued by the Company with a balance of $8,177,337 and $10,630,817 as of December 31, 2017 and 2016, respectively. Plan assets for the 401(k) plan included a group annuity contract issued by the Company with a balance of $156,854,368 and $168,614,700 as of December 31, 2017 and 2016, respectively.

11. SURPLUS AND DIVIDEND RESTRICTIONS

The portion of unassigned surplus represented by each item below as of December 31, was as follows:

	2017	2016	2015
Unrealized capital losses	$ (136,940,976)	$ (258,080,622)	$ (259,211,390)
Nonadmitted assets	(126,584,107)	(138,382,180)	(129,588,715)
AVR	(145,770,838)	(122,405,601)	(115,360,698)

The minimum statutory capital and surplus necessary to satisfy regulatory requirements was $396,856,520 as of December 31, 2017 ("company action level RBC"). Company action level RBC is the level at which a company is required to file a corrective action plan with its regulators. Company action level RBC is equal to 200% of the authorized control level RBC, which is the level at which regulatory action is taken.

Regulatory restrictions limit the amount of dividends available for distribution without prior approval of the NDOI. As of December 31, 2017, the maximum dividend allowed was $159,671,733.

12. COMMITMENTS AND CONTINGENCIES

The Company had unfunded investment commitments for bonds, mortgage loans, and other invested assets of $319,134,387 and $181,487,530 as of December 31, 2017 and 2016, respectively.

As a condition of doing business, all states and jurisdictions have adopted laws requiring membership in life and health insurance guaranty funds. Member companies are subject to assessments each year based on life, health, or annuity premiums collected in the state. The Company estimated its costs related to past insolvencies and had a liability for guaranty fund assessments of $10,742,308 and $1,555,201 as of December 31, 2017 and 2016, respectively. The Company estimated its premium tax credits that it will receive related to guaranty funds of $20,396,921 and $4,455,275 as of December 31, 2017 and 2016, respectively.

The Company recognized discounted and undiscounted amounts, based on 4.25%, relating to Penn Treaty Network America and its subsidiaries (together "Penn Treaty") during 2017. As of December 31, 2017, the discounted and undiscounted liabilities and receivables were $8,589,539 and $19,164,245, and $7,722,565 and $16,546,070, respectively. There are 50 jurisdictions for liabilities and premium tax credits by insolvency. Amounts used for the Penn Treaty accruals are the discounted amounts reported by the National Organization of Life and Health Insurance Guaranty Association.

The Company has adopted resolutions to guarantee timely payment of certain liabilities incurred by Mutual of Omaha Structured Settlement Company. The liabilities subject to this guarantee as of December 31, 2017 are $775,227,840.

Various lawsuits have arisen in the ordinary course of the Company's business. The Company believes that its defenses in these various lawsuits are meritorious and that the eventual outcome of those lawsuits will not have a material effect on the Company's financial position, results of operations, or cash flows.

13. LEASES

The Company and Mutual of Omaha jointly enter into agreements for the rental of office space, equipment, and computer software under non-cancelable operating leases. Future required minimum rental payments under leases as of December 31, 2017, were as follows:

2018	$ 9,609,141
2019	6,775,792
2020	5,024,765
2021	3,559,396
2022	2,147,580
Thereafter	10,321,193
Total	$ 37,437,867

The Company's allocated rental expense for the years ended December 31, 2017, 2016, and 2015, were $20,635,411, $17,022,741, and $19,199,267, respectively.

14. DIRECT PREMIUM WRITTEN

The Company's direct life, health, and annuity premium written by third-party administrators were $99,184,513, $143,295,031, and $98,134,213 during the years ended December 31, 2017, 2016, and 2015, respectively.

15. RETROSPECTIVELY RATED CONTRACTS

The Company estimates accrued retrospective premium adjustments for its group life and health insurance business based upon premium, claims, and expense experience for each retrospectively rated policy. This method may result in the calculation of an asset or liability for certain retrospectively rated policies.

The amount of net premium earned by the Company that was subject to retrospective rating features were approximately $5,600,000, $7,300,000, and $7,700,000 for group life business and $2,900,000, $4,900,000, and $2,500,000 for group health business during the years ended December 31, 2017, 2016, and 2015, respectively. The net premium represent 2.3%, 2.0%, and 2.0% of the total net premium for group life business and 0.5%, 1.0%, and 0.5% of the total net premium for group health business during the years ended December 31, 2017, 2016, and 2015, respectively.

16. LIABILITY FOR POLICY AND CONTRACT CLAIMS — HEALTH

A reconciliation of the policy and contract claims — health, which includes both claim liabilities and reserves, as of December 31, was as follows:

	2017	2016
Health balance at January 1	$ 781,832,988	$ 729,248,369
Reinsurance recoverable	50,361,643	46,057,348
Net balance at January 1	731,471,345	683,191,021
Incurred related to:		
Current year	928,910,214	950,608,550
Prior years	(20,018,289)	7,799,169
Total incurred	908,891,925	958,407,719
Paid related to:		
Current year	658,471,064	692,632,919
Prior years	219,217,306	217,494,476
Total paid	877,688,370	910,127,395
Net balance at December 31	762,674,900	731,471,345
Reinsurance recoverable	58,498,125	50,361,643
Balance at December 31	$ 821,173,025	$ 781,832,988

During 2017, experience related to prior years was favorable due to favorable runout within most health and accident coverages and a decrease in long term disability reserves for a termination assumption update. In 2016, incurred claims related to prior years were positive primarily due to unfavorable runout within certain health and accident coverages on a non-interest adjusted basis. On an interest adjusted basis, prior years incurred claims were favorable.

Management believes that the liability for unpaid claims is adequate to cover the ultimate development of claims. The liability is regularly reviewed and revised to reflect current conditions and claim trends and any resulting adjustments are reflected in operating results in the year they are made.

A roll forward of the liability for claim adjustment expenses included in general expenses, due or accrued, as of December 31, was as follows:

	2017	2016
Prior year accrual	$ 25,159,847	$ 23,492,281
Incurred claim adjustment expenses	41,684,552	49,568,454
Paid claim adjustment expenses	(39,760,903)	(47,900,888)
Total	$ 27,083,496	$ 25,159,847

17. RESERVES FOR LIFE, ANNUITY AND DEPOSIT-TYPE CONTRACTS

The Company waives deduction of deferred fractional premiums upon death of the insured and returns any portion of the final premium for periods beyond the monthly policy anniversary following the date of death. Surrender values are not promised in excess of the legally computed reserves.

For plans introduced prior to 1989, substandard reserves for policies with a substandard underwriting class were set equal to the excess of the reserve calculated using the appropriate substandard multiple mortality table over the reserve calculated using the standard mortality table, where both calculations use the same valuation interest rate and reserve method. For plans of insurance introduced after 1988 with a substandard underwriting class and for all policies with a flat extra substandard premium, substandard reserves were set equal to the unearned portion of the substandard premiums.

As of December 31, 2017 and 2016, the Company had insurance in force with a face value of $52,831,512,203 and $51,631,052,652, respectively, for which the gross premiums were less than the net premiums according to the valuation standards set by the NDOI. Reserves to cover the above insurance totaled $160,558,815 and $168,014,912 as of December 31, 2017 and 2016, respectively.

The mortality assumptions used for calculating reserves for anticipated anti-selection mortality on term conversions were updated resulting in an increase in reserves and a corresponding charge to surplus of $16,466,357 and $5,614,615 in 2017 and 2016, respectively.

The mortality assumptions used for calculating certain life deficiency reserves were updated resulting in an increase in reserves and a corresponding charge to surplus of $2,802,427 and $59,076,252 in 2017 and 2016, respectively.

The Company changed the effective dates for individual life policy reprices from issue date estimates to application signed dates during 2017 resulting in an increase policy reserves and corresponding charge to income of $2,800,000.

During third quarter 2016, the Company reduced certain universal life reserves to the statutory minimums. As a result of this change, reserves decreased $53,605,622 with a corresponding increase in surplus.

18. ANALYSIS OF ANNUITY RESERVES AND DEPOSIT LIABILITIES BY WITHDRAWAL CHARACTERISTICS

The withdrawal characteristics of the Company's annuity reserves and deposit-type contracts as of December 31, were as follows:

2017	General Account	Separate Account Non-guaranteed	Total	% of Total
Annuity reserves and deposit funds liabilities — subject to discretionary withdrawal:				
With fair value adjustment	$ 1,306,832,783	$ -	$ 1,306,832,783	10.0 %
At book value less current surrender charge of 5% or more	131,485,867	-	131,485,867	1.0
At fair value	-	3,931,858,313	3,931,858,313	30.1
Total with adjustment or at fair value	1,438,318,650	3,931,858,313	5,370,176,963	41.1
At book value without adjustment (minimal or no charge)	2,035,317,682	-	2,035,317,682	15.6
Not subject to discretionary withdrawal	5,647,081,011	336,762	5,647,417,773	43.3
Gross total	9,120,717,343	3,932,195,075	13,052,912,418	100.0 %
Reinsurance ceded	29,889,701	-	29,889,701	
Net total	$ 9,090,827,642	$ 3,932,195,075	$ 13,023,022,717	

2016	General Account	Separate Account Non-guaranteed	Total	% of Total
Annuity reserves and deposit funds liabilities — subject to discretionary withdrawal:				
With fair value adjustment	$ 1,272,974,751	$ -	$ 1,272,974,751	10.8 %
At book value less current surrender charge of 5% or more	145,645,348	-	145,645,348	1.2
At fair value	-	3,319,011,737	3,319,011,737	28.4
Total with adjustment or at fair value	1,418,620,099	3,319,011,737	4,737,631,836	40.4
At book value without adjustment (minimal or no charge)	1,999,088,678	-	1,999,088,678	17.0
Not subject to discretionary withdrawal	4,999,599,959	253,707	4,999,853,666	42.6
Gross total	8,417,308,736	3,319,265,444	11,736,574,180	100.0 %
Reinsurance ceded	31,032,076	-	31,032,076	
Net total	$ 8,386,276,660	$ 3,319,265,444	$ 11,705,542,104	

Annuity reserves and deposit funds liabilities subject to discretionary withdrawal at fair value includes runoff variable annuity reserves for policies which are 100% ceded under a modified coinsurance reinsurance agreement to a third party. A portion of these policies may be subject to surrender charges at certain policy durations.

There were no annuity reserves or deposit liabilities in guaranteed separate accounts as of December 31, 2017 and 2016.

The following information is obtained from the applicable exhibit in the Company's annual statement and related separate accounts annual statement, both of which were filed with the NDOI and are provided to reconcile annuity reserves, supplementary contracts with life contingencies, and deposit-type funds to amounts reported in the statutory financial statements as of December 31.

	2017	2016
Life and accident and health annual statement:		
Exhibit 5, Annuities section — net total	$ 6,257,750,384	$ 5,689,047,134
Exhibit 5, Supplementary Contracts with Life Contingencies section — net total	5,293,919	5,506,715
Exhibit 7, Deposit-Type Contracts, Line 14, Column 1	2,827,783,339	2,691,722,811
Subtotal	9,090,827,642	8,386,276,660
Separate accounts annual statement:		
Exhibit 3, Line 0299999, Column 2	101,430,370	94,274,909
Page 3, Line 2, Column 3 — Other Contract Deposit Funds	3,830,764,705	3,224,990,535
Total	$ 13,023,022,717	$ 11,705,542,104

19. PREMIUMS DEFERRED AND UNCOLLECTED

Deferred and uncollected life insurance premiums and annuity considerations as of December 31, were as follows:

	2017		2016	
Type	Gross	Net of Loading	Gross	Net of Loading
Ordinary first year business	$ 107,112,491	$ 12,683,309	$ 93,677,014	$ 10,337,332
Ordinary renewal	389,095,035	305,984,157	346,616,425	276,412,408
Group life	(61,807,352)	(62,612,758)	(55,211,102)	(56,038,615)
Total	$ 434,400,174	$ 256,054,708	$ 385,082,337	$ 230,711,125

20. SEPARATE ACCOUNTS

Information regarding the non-guaranteed separate accounts of the Company as of December 31, was as follows:

	2017	2016
For the years ended December 31:		
Premiums and considerations	$ 3,886,984	$ 4,210,326
Deposits	1,504,047,869	1,506,560,862
Premiums, considerations, and deposits	$ 1,507,934,853	$ 1,510,771,188
As of December 31:		
Reserves by valuation basis — fair value	$ 3,990,779,494	$ 3,371,315,165
Reserves by withdrawal characteristics — fair value	$ 3,990,779,494	$ 3,371,315,165
Transfers as reported in the statutory statements of operations of the separate accounts annual statement:		
Transfers to separate accounts	$ 3,886,984	$ 4,223,366
Transfers from separate accounts	11,653,182	11,788,916
Net transfers of the general account	(7,766,198)	(7,565,550)
Reinsurance of separate account business	7,766,198	7,565,550
Net transfers as reported in the statutory statements of operations	$ -	$ -

The Company holds no guaranteed separate accounts or reserves in separate accounts for asset default risk in lieu of AVR as of December 31, 2017 and 2016.

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SUPPLEMENTAL SCHEDULES

Deloitte.

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INDEPENDENT AUDITORS' REPORT ON ADDITIONAL INFORMATION

To the Board of Directors
United of Omaha Life Insurance Company
Omaha, Nebraska

Our 2017 audit was conducted for the purpose of forming an opinion on the 2017 statutory-basis financial statements as a whole. The supplemental schedule of selected financial data, the supplemental summary investment schedule, and the supplemental schedule of investment risks interrogatories as of and for the year ended December 31, 2017, are presented for purposes of additional analysis and are not a required part of the 2017 statutory-basis financial statements. These schedules are the responsibility of the Company's management and were derived from and relate directly to the underlying accounting and other records used to prepare the statutory-basis financial statements. Such schedules have been subjected to the auditing procedures applied in our audit of the 2017 statutory-basis financial statements and certain additional procedures, including comparing and reconciling such schedules directly to the underlying accounting and other records used to prepare the statutory-basis financial statements or to the statutory-basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such schedules are fairly stated in all material respects in relation to the 2017 statutory-basis financial statements as a whole.

Deloitte & Touche LLP

April 19, 2018

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA
AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

Investment income earned:	
U.S. government bonds	$ 28,381,756
Other bonds (unaffiliated)	611,473,927
Bonds of affiliates	685,436
Preferred stocks (unaffiliated)	1,168,478
Preferred stocks of affiliates	-
Common stocks (unaffiliated)	1,370
Common stocks of affiliates	-
Mortgage loans	95,715,164
Real estate	15,078,888
Contract loans	11,913,709
Cash and cash equivalents	2,549,409
Short-term investments	184,866
Other invested assets	7,356,608
Derivative instruments	5,899,394
Aggregate write-ins for investment income	1,097,001
Gross investment income	$ 781,506,006
Real estate owned — book value less encumbrances	$ 48,610,811
Mortgage loans — book value:	
Farm mortgages	$ -
Residential mortgages	-
Commercial mortgages	2,118,511,798
Total mortgage loans	$ 2,118,511,798
Mortgage loans by standing — book value:	
Good standing	$ 2,118,511,798
Good standing with restructured terms	$ -
Interest overdue more than three months, not in foreclosure	$ -
Foreclosure in process	$ -
Other long-term assets — statement value	$ 161,281,936
Collateral loans	$ -

(Continued)

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA
AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

Bonds and stocks of subsidiaries and affiliates — book value:	
Bonds	$ -
Preferred stocks	$ -
Common stocks	$ 117,179,140
Bonds and Short-term Investments by NAIC designation and maturity:	
Bonds by maturity — statement value:	
Due within one year or less	$ 996,136,920
Over 1 year and through 5 years	4,519,664,530
Over 5 years through 10 years	3,254,718,568
Over 10 years through 20 years	2,986,718,719
Over 20 years	3,197,631,857
No maturity date	51,362,502
Total by maturity	$ 15,006,233,096
Bonds and Short-term Investments by NAIC designation — statement value:	
NAIC 1	$ 7,734,409,631
NAIC 2	6,554,739,407
NAIC 3	596,026,982
NAIC 4	98,816,637
NAIC 5	21,102,634
NAIC 6	1,137,805
Total by NAIC designation	$ 15,006,233,096
Total bonds publicly traded	$ 6,348,020,208
Total bonds privately placed	$ 8,658,212,888
Preferred stocks — statement value	$ 131,800,000
Common stocks	$ 165,137,859
Short-term investments — book value	$ 104,786,154
Options, caps, and floors owned — statement value	$ (23,872,292)
Options, caps, and floors written and in force — statement value	$ -
Collar, swap, and forward agreements open — current value	$ -
Cash on deposit	$ (13,079,297)

(Continued)

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA
AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

Life insurance in force (in thousands):	
Industrial	$ -
Ordinary	$ 174,446,938
Credit life	$ -
Group life	$ 187,579,820
Amount of accidental death insurance in force under ordinary policies (in thousands)	$ 4,188,307
Life insurance with disability provisions in force (in thousands):	
Industrial	$ -
Ordinary	$ 9,611,243
Credit life	$ -
Group life	$ 179,388,641
Supplementary contracts in force:	
Ordinary — not involving life contingencies:	
Amount on deposit	$ 42,033,177
Income payable	$ 943,750
Ordinary — involving life contingencies — income payable	$ 697,195
Group — not involving life contingencies:	
Amount on deposit	$ -
Income payable	$ -
Group — involving life contingencies — income payable	$ 16,694
Annuities:	
Ordinary:	
Immediate — amount of income payable	$ 117,643,106
Deferred — fully paid account balance	$ 1,406,292,274
Deferred — not fully paid account balance	$ 799,104,197

(Continued)

UNITED OF OMAHA LIFE INSURANCE COMPANY
(A Wholly Owned Subsidiary of Mutual of Omaha Insurance Company)

SUPPLEMENTAL SCHEDULE OF SELECTED FINANCIAL DATA
AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2017

Group:	
Amount of income payable	$ 249,563,251
Fully paid account balance	$ 425,750,869
Not fully paid account balance	$ 17,811,197
Accident and health insurance — Premiums in force:	
Ordinary	$ 1,074,781,833
Group	$ 644,526,691
Credit	$ -
Deposit funds and dividend accumulations:	
Deposit funds — account balance	$ 2,785,741,364
Dividend accumulations — account balance	$ 8,798
Claim payments 2017:	
Group accident and health — year ended December 31, 2017:	
2017	$ 167,606,786
2016	$ 74,509,983
2015	$ 28,033,474
2014	$ 15,198,587
2013	$ 7,769,341
2012 & prior	$ 37,556,547
Other accident and health — year ended December 31, 2017:	
2017	$ 490,864,278
2016	$ 56,176,833
2015	$ 276,664
2014	$ (88,416)
2013	$ (71,064)
2012 & prior	$ (144,643)

(Continued)

Claim payments 2017 (continued):

Other coverages that use developmental methods to calculate claim reserves:

2017	$ -
2016	$ -
2015	$ -
2014	$ -
2013	$ -
2012 & prior	$ -

(Concluded)

SUMMARY INVESTMENT SCHEDULE

	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
Investment Categories	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities	86,765,094	0.479	86,765,094	0	86,765,094	0.479
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.000	0	0	0	0.000
1.22 Issued by U.S. government sponsored agencies	100,166,530	0.553	100,166,530	0	100,166,530	0.553
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)	19,195,635	0.106	19,195,635	0	19,195,635	0.106
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	15,087,803	0.083	15,087,803	0	15,087,803	0.083
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	0	0.000	0	0	0	0.000
1.43 Revenue and assessment obligations	92,447,558	0.510	92,447,558	0	92,447,558	0.510
1.44 Industrial development and similar obligations	8,490,000	0.047	8,490,000	0	8,490,000	0.047
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	422,709,512	2.332	422,709,512	0	422,709,512	2.332
1.512 Issued or guaranteed by FNMA and FHLMC	97,246,875	0.536	97,246,875	0	97,246,875	0.536
1.513 All other	35,951,428	0.198	35,951,428	0	35,951,428	0.198
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	599,599,324	3.308	599,599,324	0	599,599,324	3.308
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	14,757,006	0.081	14,757,006	0	14,757,006	0.081
1.523 All other	112,447,795	0.620	112,447,795	0	112,447,795	0.620
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	9,695,641,151	53.489	9,695,641,151	0	9,695,641,151	53.489
2.2 Unaffiliated non-U.S. securities (including Canada)	3,560,017,903	19.640	3,560,017,903	0	3,560,017,903	19.640
2.3 Affiliated securities	37,914,030	0.209	37,914,030	0	37,914,030	0.209
3. Equity interests:						
3.1 Investments in mutual funds	0	0.000	0	0	0	0.000
3.2 Preferred stocks:						
3.21 Affiliated	0	0.000	0	0	0	0.000
3.22 Unaffiliated	131,800,000	0.727	131,800,000	0	131,800,000	0.727
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.000	0	0	0	0.000
3.32 Unaffiliated	9,211,219	0.051	9,211,219	0	9,211,219	0.051
3.4 Other equity securities:						
3.41 Affiliated	117,179,140	0.646	117,179,140	0	117,179,140	0.646
3.42 Unaffiliated	38,747,500	0.214	38,747,500	0	38,747,500	0.214
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.000	0	0	0	0.000
3.52 Unaffiliated	0	0.000	0	0	0	0.000
4. Mortgage loans:						
4.1 Construction and land development	0	0.000	0	0	0	0.000
4.2 Agricultural	14,000,000	0.077	14,000,000	0	14,000,000	0.077
4.3 Single family residential properties	0	0.000	0	0	0	0.000
4.4 Multifamily residential properties	0	0.000	0	0	0	0.000
4.5 Commercial loans	2,104,511,798	11.610	2,104,511,798	0	2,104,511,798	11.610
4.6 Mezzanine real estate loans	0	0.000	0	0	0	0.000
5. Real estate investments:						
5.1 Property occupied by company	48,610,812	0.268	48,610,812	0	48,610,812	0.268
5.2 Property held for production of income (including $ 0 of property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
5.3 Property held for sale (including $ 0 property acquired in satisfaction of debt)	0	0.000	0	0	0	0.000
6. Contract loans	184,171,324	1.016	184,171,324	0	184,171,324	1.016
7. Derivatives	20,598,924	0.114	20,598,924	0	20,598,924	0.114
8. Receivables for securities	10,157,405	0.056	10,157,405	0	10,157,405	0.056
9. Securities Lending (Line 10, Asset Page reinvested collateral)	287,498,568	1.586	287,498,568	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	100,377,997	0.554	100,377,997	287,498,568	387,876,565	2.140
11. Other invested assets	161,281,936	0.890	161,281,936	0	161,281,936	0.890
12. Total invested assets	18,126,584,262	100.000	18,126,584,262	287,498,568	18,126,584,262	100.000

SUPPLEMENTAL INVESTMENT RISKS INTERROGATORIES

For The Year Ended December 31, 2017
(To Be Filed by April 1)

Of The United of Omaha Life Insurance Company

ADDRESS (City, State and Zip Code) Omaha , NE 68175

NAIC Group Code 0261 NAIC Company Code 69868 Federal Employer's Identification Number (FEIN) 47-0322111

The Investment Risks Interrogatories are to be filed by April 1. They are also to be included with the Audited Statutory Financial Statements.

Answer the following interrogatories by reporting the applicable U.S. dollar amounts and percentages of the reporting entity's total admitted assets held in that category of investments.

1. Reporting entity's total admitted assets as reported on Page 2 of this annual statement. $ 18,805,284,799

2. Ten largest exposures to a single issuer/borrower/investment.

	1 Issuer	2 Description of Exposure	3 Amount	4 Percentage of Total Admitted Assets
2.01	ESSENCE GROUP HOLDINGS CORP	Preferred Stock	$ 100,000,000	0.5 %
2.02	MUTUAL OF OMAHA INSURANCE CO	Insurance Affiliate Short Term Revolver	$ 95,000,000	0.5 %
2.03	FULCRUM GROWTH PARTNERS	Equity Partnerships	$ 58,134,725	0.3 %
2.04	COMPANION LIFE INSURANCE CO	Insurance Affiliate Stock	$ 57,412,745	0.3 %
2.05	PHILLIPS 66 COMPANY	Corporate Bonds	$ 56,152,615	0.3 %
2.06	APPLE INC	Corporate Bonds	$ 56,068,941	0.3 %
2.07	COMCAST CORP	Corporate Bonds	$ 54,762,079	0.3 %
2.08	BROOKFIELD FINANCE LLC	Corporate Bonds	$ 53,021,810	0.3 %
2.09	QUALCOMM INCORPORATED	Corporate Bonds	$ 52,850,653	0.3 %
2.10	MICROSOFT CORP	Corporate Bonds	$ 52,507,997	0.3 %

3. Amounts and percentages of the reporting entity's total admitted assets held in bonds and preferred stocks by NAIC designation.

	Bonds	1	2		Preferred Stocks	3	4
3.01	NAIC-1	$ 7,734,409,631	41.1 %	3.07	P/RP-1	$ 31,800,000	0.2 %
3.02	NAIC-2	$ 6,554,739,407	34.9 %	3.08	P/RP-2	$ 0	0.0 %
3.03	NAIC-3	$ 596,026,982	3.2 %	3.09	P/RP-3	$ 0	0.0 %
3.04	NAIC-4	$ 98,816,637	0.5 %	3.10	P/RP-4	$ 0	0.0 %
3.05	NAIC-5	$ 21,102,634	0.1 %	3.11	P/RP-5	$ 0	0.0 %
3.06	NAIC-6	$ 1,137,805	0.0 %	3.12	P/RP-6	$ 100,000,000	0.5 %

4. Assets held in foreign investments:

4.01 Are assets held in foreign investments less than 2.5% of the reporting entity's total admitted assets? Yes [ ] No [X]

If response to 4.01 above is yes, responses are not required for interrogatories 5 - 10.

4.02	Total admitted assets held in foreign investments	$ 3,599,962,048	19.1 %
4.03	Foreign-currency-denominated investments	$ 0	0.0 %
4.04	Insurance liabilities denominated in that same foreign currency	$ 0	0.0 %

5. Aggregate foreign investment exposure categorized by NAIC sovereign designation:

		1	2
5.01	Countries designated NAIC-1	$ 3,580,232,048	19.0 %
5.02	Countries designated NAIC-2	$ 6,000,000	0.0 %
5.03	Countries designated NAIC-3 or below	$ 13,730,000	0.1 %

6. Largest foreign investment exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
6.01	Country 1: United Kingdom	$ 1,107,584,458	5.9 %
6.02	Country 2: Australia	$ 670,815,919	3.6 %
	Countries designated NAIC - 2:		
6.03	Country 1: Spain	$ 6,000,000	0.0 %
6.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
6.05	Country 1: Bahamas	$ 13,730,000	0.1 %
6.06	Country 2:	$ 0	0.0 %

		1	2
7.	Aggregate unhedged foreign currency exposure	$ 600,667	0.0 %

8. Aggregate unhedged foreign currency exposure categorized by NAIC sovereign designation:

		1	2
8.01	Countries designated NAIC-1	$ 600,667	0.0 %
8.02	Countries designated NAIC-2	$ 0	0.0 %
8.03	Countries designated NAIC-3 or below	$ 0	0.0 %

9. Largest unhedged foreign currency exposures by country, categorized by the country's NAIC sovereign designation:

		1	2
	Countries designated NAIC - 1:		
9.01	Country 1: United Kingdom	$ 600,667	0.0 %
9.02	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 2:		
9.03	Country 1:	$ 0	0.0 %
9.04	Country 2:	$ 0	0.0 %
	Countries designated NAIC - 3 or below:		
9.05	Country 1:	$ 0	0.0 %
9.06	Country 2:	$ 0	0.0 %

10. Ten largest non-sovereign (i.e. non-governmental) foreign issues:

	1 Issuer	2 NAIC Designation	3	4
10.01	DEUTSCHE TELEKOM INTL FIN BV - Netherlands	2	$ 46,385,192	0.2 %
10.02	GPT RE LIMITED - Australia	1	$ 45,000,000	0.2 %
10.03	JOHNSON CONTROLS INTL PLC - Ireland	2	$ 44,874,647	0.2 %
10.04	WOLSELEY CAPITAL INC - United Kingdom	2	$ 44,134,023	0.2 %
10.05	COVENT GARDEN GRP HLDGS LTD - United Kingdom	1	$ 43,241,600	0.2 %
10.06	INVESCO FINANCE PLC - United Kingdom	1	$ 41,986,370	0.2 %
10.07	CARIBBEAN UTILITIES CO LTD - Cayman Islands	1	$ 41,000,000	0.2 %
10.08	MEDTRONIC INC - Ireland	1	$ 40,349,877	0.2 %
10.09	EATON CORPORATION - Ireland	2	$ 38,453,059	0.2 %
10.10	TRITON CONTAINER INTL LIMITED - Bermuda	2	$ 38,428,571	0.2 %

11. Amounts and percentages of the reporting entity's total admitted assets held in Canadian investments and unhedged Canadian currency exposure:

11.01 Are assets held in Canadian investments less than 2.5% of the reporting entity's total admitted assets? ..... Yes [ ] No [X]

If response to 11.01 is yes, detail is not required for the remainder of interrogatory 11.

		1	2
11.02	Total admitted assets held in Canadian investments	$ 651,202,314	3.5 %
11.03	Canadian-currency-denominated investments	$ 0	0.0 %
11.04	Canadian-denominated insurance liabilities	$ 0	0.0 %
11.05	Unhedged Canadian currency exposure	$ 0	0.0 %

12. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments with contractual sales restrictions:

12.01 Are assets held in investments with contractual sales restrictions less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 12.01 is yes, responses are not required for the remainder of interrogatory 12.

		1	2	3
12.02	Aggregate statement value of investments with contractual sales restrictions	$ 0	0.0 %	
	Largest three investments with contractual sales restrictions:			
12.03		$ 0	0.0 %	
12.04		$ 0	0.0 %	
12.05		$ 0	0.0 %	

13. Amounts and percentages of admitted assets held in the ten largest equity interests:

13.01 Are assets held in equity interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 13.01 above is yes, responses are not required for the remainder of interrogatory 13.

	1 Issuer	2	3
13.02		$ 0	0.0 %
13.03		$ 0	0.0 %
13.04		$ 0	0.0 %
13.05		$ 0	0.0 %
13.06		$ 0	0.0 %
13.07		$ 0	0.0 %
13.08		$ 0	0.0 %
13.09		$ 0	0.0 %
13.10		$ 0	0.0 %
13.11		$ 0	0.0 %

14. Amounts and percentages of the reporting entity's total admitted assets held in nonaffiliated, privately placed equities:

14.01 Are assets held in nonaffiliated, privately placed equities less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 14.01 above is yes, responses are not required for the remainder of Interrogatory 14.

	1	2	3
14.02	Aggregate statement value of investments held in nonaffiliated, privately placed equities	$ 0	0.0 %
	Largest three investments held in nonaffiliated, privately placed equities:		
14.03		$ 0	0.0 %
14.04		$ 0	0.0 %
14.05		$ 0	0.0 %

15. Amounts and percentages of the reporting entity's total admitted assets held in general partnership interests:

15.01 Are assets held in general partnership interests less than 2.5% of the reporting entity's total admitted assets? ..... Yes [X] No [ ]

If response to 15.01 above is yes, responses are not required for the remainder of Interrogatory 15.

	1	2	3
15.02	Aggregate statement value of investments held in general partnership interests	$ 0	0.0 %
	Largest three investments in general partnership interests:		
15.03		$ 0	0.0 %
15.04		$ 0	0.0 %
15.05		$ 0	0.0 %

16. Amounts and percentages of the reporting entity's total admitted assets held in mortgage loans:

16.01 Are mortgage loans reported in Schedule B less than 2.5% of the reporting entity's total admitted assets? ..... Yes [ ] No [X]

If response to 16.01 above is yes, responses are not required for the remainder of Interrogatory 16 and Interrogatory 17.

	1 Type (Residential, Commercial, Agricultural)	2	3
16.02	Commercial - THE LINKS AT BENTONVILLE LP	$ 35,056,382	0.2 %
16.03	Commercial - THE IRVINE COMPANY LLC	$ 34,976,712	0.2 %
16.04	Commercial - SLG 220 NEWS OWNER LLC	$ 34,966,334	0.2 %
16.05	Commercial - BRE/OC RED HILL LLC	$ 29,995,083	0.2 %
16.06	Commercial - SUNSET LAND COMPANY LLC	$ 26,388,749	0.1 %
16.07	Commercial - WRI RETAIL POOL I, L.P.	$ 25,264,295	0.1 %
16.08	Commercial - ALEXANDER 375 WEST BROADWAY LLC	$ 20,000,000	0.1 %
16.09	Commercial - AMERICAN FIDELITY ASSURANCE COMPANY	$ 19,637,236	0.1 %
16.10	Commercial - BERKSHIRE MALL LLC	$ 18,278,441	0.1 %
16.11	Commercial - SOMERSET WOODS ASSOCIATES LLC	$ 18,000,000	0.1 %

Amount and percentage of the reporting entity's total admitted assets held in the following categories of mortgage loans:

		Loans	
16.12	Construction loans	$ 0	0.0 %
16.13	Mortgage loans over 90 days past due	$ 0	0.0 %
16.14	Mortgage loans in the process of foreclosure	$ 0	0.0 %
16.15	Mortgage loans foreclosed	$ 0	0.0 %
16.16	Restructured mortgage loans	$ 7,933,488	0.0 %

17. Aggregate mortgage loans having the following loan-to-value ratios as determined from the most current appraisal as of the annual statement date:

		Residential		Commercial		Agricultural	
	Loan to Value	1	2	3	4	5	6
17.01	above 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.02	91 to 95%	$ 0	0.0 %	$ 0	0.0 %	$ 0	0.0 %
17.03	81 to 90%	$ 0	0.0 %	$ 1,048,600	0.0 %	$ 0	0.0 %
17.04	71 to 80%	$ 0	0.0 %	$ 20,211,208	0.1 %	$ 0	0.0 %
17.05	below 70%	$ 0	0.0 %	$ 2,083,251,990	11.1 %	$ 14,000,000	0.1 %

18. Amounts and percentages of the reporting entity's total admitted assets held in each of the five largest investments in real estate:

18.01 Are assets held in real estate reported less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 18.01 above is yes, responses are not required for the remainder of Interrogatory 18.

Largest five investments in any one parcel or group of contiguous parcels of real estate.

	Description 1	2	3
18.02		$ 0	0.0 %
18.03		$ 0	0.0 %
18.04		$ 0	0.0 %
18.05		$ 0	0.0 %
18.06		$ 0	0.0 %

19. Report aggregate amounts and percentages of the reporting entity's total admitted assets held in investments held in mezzanine real estate loans:

19.01 Are assets held in investments held in mezzanine real estate loans less than 2.5% of the reporting entity's total admitted assets? Yes [X] No [ ]

If response to 19.01 is yes, responses are not required for the remainder of Interrogatory 19.

	1	2	3
19.02	Aggregate statement value of investments held in mezzanine real estate loans:	$ 0	0.0 %
	Largest three investments held in mezzanine real estate loans:		
19.03		$ 0	0.0 %
19.04		$ 0	0.0 %
19.05		$ 0	0.0 %

20. Amounts and percentages of the reporting entity's total admitted assets subject to the following types of agreements:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
20.01	Securities lending agreements (do not include assets held as collateral for such transactions)	$ 381,603,107	2.0 %	$ 343,967,005	$ 328,291,730	$ 332,367,905
20.02	Repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.03	Reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.04	Dollar repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0
20.05	Dollar reverse repurchase agreements	$ 0	0.0 %	$ 0	$ 0	$ 0

21. Amounts and percentages of the reporting entity's total admitted assets for warrants not attached to other financial instruments, options, caps, and floors:

		Owned		Written	
		1	2	3	4
21.01	Hedging	$ 2,590,493	0.0 %	$ 0	0.0 %
21.02	Income generation	$ 0	0.0 %	$ (25,346)	0.0 %
21.03	Other	$ 341,244	0.0 %	$ 0	0.0 %

22. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for collars, swaps, and forwards:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
22.01	Hedging	$ 10,978,713	0.1 %	$ 7,787,201	$ 8,915,619	$ 9,942,316
22.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
22.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
22.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

23. Amounts and percentages of the reporting entity's total admitted assets of potential exposure for futures contracts:

		At Year End		At End of Each Quarter		
		1	2	1st Quarter 3	2nd Quarter 4	3rd Quarter 5
23.01	Hedging	$ 0	0.0 %	$ 0	$ 0	$ 0
23.02	Income generation	$ 0	0.0 %	$ 0	$ 0	$ 0
23.03	Replications	$ 0	0.0 %	$ 0	$ 0	$ 0
23.04	Other	$ 0	0.0 %	$ 0	$ 0	$ 0

Employer Contract
Sample

YOUR GROUP
TERM LIFE BENEFITS

FOR EMPLOYEES OF:

ABC Company

CLASS(ES):

All eligible exempt employees

REVISION EFFECTIVE DATE:

October 1, 2016

PUBLICATION DATE:

September 30, 2016

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF KENTUCKY.

FRAUD WARNING
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Group Number: G0001234

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of You at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Living Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect Your, Your Spouse's or Your family's eligibility for public assistance.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-1234 (the Policy) has been issued to ABC Company (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Richard C. Anderl
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All eligible exempt employees

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is an amount equal to 2 times Your Annual Earnings, but in no event less than $10,000 or more than $200,000. Your amount of life insurance will be rounded to the next higher multiple of $1,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENT(S)

Your Spouse's amount of life insurance is $5,000.

The amount of life insurance for Your eligible Dependent child(ren) is based on the age of the Dependent, as follows:

Age of Dependent Child	Amount of Life Insurance
Six months and older	$5,000
14 days to less than six months	$1,250
Less than 14 days	$0

If You have questions regarding the amount of life insurance for Your Dependent(s), You may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder.

EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

BENEFIT REDUCTIONS

As You grow older, the amount of life and AD&D insurance for You will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce by:
70	50%
75	65%

Reductions become effective on the first day of the Policy month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If You are age 70 or older on the date insurance becomes effective, the amount of life and AD&D insurance for You will be reduced as shown above. Thereafter, the amount of life and AD&D insurance will continue to reduce in accord with the schedule above.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

Actively Working, Active Work means an Employee is performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 30 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed oneself);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function);
f) toileting (the ability to use a restroom); and
g) moving around (as opposed to being bedridden).

Disability Elimination Period means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

Partial Disability, Partially Disabled means that, because of an Injury or Sickness lasting longer than 12 months, You are unable to perform the normal duties of Your regular job for the Policyholder on a regular or continuous basis, but are able to satisfy all other requirements of the Active Work definition.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

Total Disability, Totally Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent.

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WAIVER OF PARTICIPATION IN A NON-CONTRIBUTORY PLAN

An Employee may choose to waive participation in the Policy if premiums are 100% paid by the Policyholder (if the plan is non-contributory), due to any of the following:

a) for religious or faith-based reasons;
b) to avoid possible federal and/or state income tax liability; or
c) for any other reason approved by Us.

For the waiver of participation to be considered by Us, the Employee must submit a Written Request. The request must be signed by the Employee, and in community property states, the Employee's Spouse, if applicable. The waiver will not be effective until the Written Request is received and recorded by Us.

The waiver will be irrevocable for one full year from the date it is recorded by Us. After one full year has passed, if the Employee would like to become insured or reinstate insurance under the Policy, Evidence of Insurability will be required. Such evidence must be obtained at the Employee's own expense. Insurance will not begin until after We approve Evidence of Insurability.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:

a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not eligible for benefits or continuation of insurance under any provision of the Prior Plan;
d) is not a retired Employee; and
e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:

a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to Us when due; and
e) insurance is subject to any reductions shown in the Schedule and all other terms and conditions of the Policy.

If insurance is provided for the Employee, insurance may also be provided for any eligible Dependent(s).

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision; or
d) the last day of the twelfth month following the Policy Effective Date.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision or the Portability provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Conversion provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the first day of the month that coincides with or follows the latest of the day:

a) the Employee begins Active Work; or
b) the Employee submits a Written Request to enroll for insurance, if applicable.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

An eligible Dependent will become insured on the latest of the day:

a) the Employee becomes insured, unless otherwise agreed to by Our authorized representative in Our home office;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if applicable.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee or Dependent who is:

a) Totally Disabled (with respect to the Employee);
b) confined in a Hospital as an inpatient;
c) confined in any institution or facility other than a Hospital; or
d) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work or Dependent is no longer confined.

Insurance for an Employee who is not Actively Working on the Policy Effective Date due to Injury or Sickness will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day the Dependent has performed all ADLs for at least 15 consecutive days.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 21, or age 25 if a Student, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your or Your Dependent's class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the date of the request or the change.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended for You and/or Your Dependent(s) in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date You and/or Your Dependent(s) become eligible for insurance. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Transfer From Portability or Conversion

If insurance was obtained under the Portability or Conversion provision while an Employee was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any insurance provided through the Portability provision will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You or any of Your Dependent(s) cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You or any of Your Dependent(s), and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and/or Your Dependent(s) would otherwise end, You and/or Your Dependent(s) may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Injury or Sickness
c) Continuation of Insurance for Partial Disability
d) Continuation of Insurance for Total Disability with Waiver of Premium
e) Portability
f) Conversion

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. end of the month for Your temporary involuntary layoff;
    2. end of the month for Your leave of absence; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision; and
c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Injury or Sickness provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the day:

a) that is 12 months from the day You cease Active Work;
b) You return to Active Work;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Partial Disability provision, Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision, You may be able to continue insurance under this provision due to Your Partial Disability. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Partially Disabled, but not Totally Disabled; and
b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the day:

a) You return to Active Work;
b) Your Injury or Sickness results in Your Total Disability and You are eligible to continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your Partial Disability may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

This provision only allows for continuation of life insurance under the Policy. Accidental death and dismemberment insurance may not be continued under this provision.

When Your insurance ends under the Continuation of Insurance for Injury or Sickness provision or Continuation of Insurance for Partial Disability provision, You may be able to continue insurance under this provision due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Totally Disabled;
b) You were under age 60 at the time You became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

Insurance may only be continued for You. If You are able to continue insurance under this provision, Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

If You are age 60 or older and become Totally Disabled, You and Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 9 consecutive months. Any period of time in which You are insured under the Continuation of Insurance for Injury or Sickness provision will apply toward satisfaction of the Disability Elimination Period.

Proof of Total Disability

You must submit to Us acceptable proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at Your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You and Your Dependent(s) will have 31 days from the date of Our notice to submit a Written Request for insurance under the Portability or Conversion provision, if You have not returned to Active Work or You are not eligible for insurance under the Continuation of Insurance for Partial Disability provision.

When Insurance Under this Provision Ends

Insurance under this provision will end on the day:

a) You are eligible to continue insurance under the Continuation of Insurance for Partial Disability provision; or
b) You return to Active Work.

Insurance under this provision will also end on the earliest of the day:

a) You are no longer Totally Disabled;
b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
d) You reach age 65; or
e) You begin full-time employment with an employer other than the Policyholder.

Insurance under this provision will also end in accordance with the Grace Period provision.

PORTABILITY

You have the right to continue receiving group life and accidental death and dismemberment insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment with the Policyholder ends;
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

In addition to the above reasons, Your Spouse has the right to continue receiving group insurance, including insurance for Dependent child(ren), under this provision if Your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:

a) You continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
b) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
c) divorce or legal separation of You and Your Spouse; or
d) Your death.

If Your Spouse continues to receive insurance under this provision, Dependent child(ren) may be insured under You or Your Spouse, but not both.

If You are eligible for insurance under this provision and You are not eligible for insurance under any other continuation provision of the Policy, You must continue insurance under this provision in order for Your Dependent(s) to be eligible.

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance for each Insured Person shall not exceed the lesser of:

a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000 for You and $250,000 for Your Dependents.

The amount of insurance may not be increased after insurance continues under this provision.

If You continue to receive group insurance under this provision, You and Your Dependent(s) can not continue insurance under any other continuation provision of the Policy (if applicable).

The Group Term Life Insurance Portability Policy

Group insurance continued under this provision is available under another group term life insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You or Your Spouse become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy ends ("Portability Period"). When insurance under the Policy ends, notice of the right to continue receiving insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to apply for a Portability Policy will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Continue Group Insurance Under this Provision

You or Your Spouse must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

When Employment or Class Membership Ends or the Amount of Insurance Reduces

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy"). If group life insurance for any of Your Dependent(s) ends or reduces due to Your death, divorce, legal separation or failure to satisfy any other eligibility condition, Your Dependent(s) may also apply for a Conversion Policy.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You and/or Your Dependent(s) may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits;
c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If You or any of Your Dependent(s) are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You or Your Dependent(s) did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or Your Dependent(s) must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If You or any of Your Dependent(s) are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 31 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance for You and/or Your Dependent(s) will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for You and/or Your Dependent(s) will terminate during the grace period. If We receive such notice, insurance will terminate for You and/or Your Dependent(s) on the date requested.

If any premium due is not paid during the grace period, insurance for You and/or Your Dependent(s) will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance for You and/or Your Dependent(s), the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for You and/or Your Dependent(s) in accordance with the terms of the Policy, or a change in the amount of insurance for You and/or Your Dependent(s) as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach an age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
b) premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You or any of Your Dependent(s), if applicable. Benefits payable by reason of Your death will be paid to Your beneficiary. Benefits payable by reason of the death of Your Dependent(s), if applicable, will be paid to You.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

a) Your surviving Spouse; if none, then to
b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
c) Your surviving parent(s), in equal shares; if none, then to
d) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

You are the beneficiary of Your Dependent(s) benefits. If You are not living at the time of the death of any of Your Dependent(s), the following will apply:

a) In the event of the death of Your Spouse, benefits will be paid to Your Spouse's estate.
b) In the event of the death of any of Your Dependent child(ren), benefits will be paid to Your Spouse, if Your Spouse is living. If Your Spouse is not living, benefits will be paid in equal shares to the deceased child's living siblings. If there are no living siblings, benefits will be paid to the estate of the deceased child.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

FACILITY OF PAYMENT

We may pay an amount of up to $2,000 to any person or entity that has incurred expenses related to Your death and subsequent burial, or to the death and subsequent burial of any of Your Dependent(s), if applicable. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIVING BENEFITS (ACCELERATED BENEFIT)

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

This section only applies to the life insurance offered by the Policy. Accidental death and dismemberment (AD&D) insurance is not included under this section.

The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting Living Benefits.

DEFINITIONS

Living Benefits means an advance payment of part of Your life insurance death benefit.

Terminal Condition means an Injury or Sickness that is expected to result in Your death within the next 12 months as certified by an attending Physician's written statement.

ABOUT LIVING BENEFITS

If You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or $150,000, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or $1,000, whichever is greater.

We will pay Living Benefits to You in a lump sum, provided You are living at the time payment is made.

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You. Life insurance on other Insured Persons, if any, is not affected by payment of Living Benefits for You. Payment of Living Benefits has no effect on accidental death and dismemberment (AD&D) insurance benefits.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, You, Your Spouse or Your legal representative must provide Us:

a) a Written Request for Living Benefits;
b) satisfactory proof of Your Terminal Condition, including an attending Physician's written statement; and
c) a statement of consent from any beneficiary(ies) or assignee(s).

You, Your Spouse or Your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for You only once under the Policy;
b) You can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) Premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You; and
e) The Portability provision is not available for You after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when You have irrevocably assigned life insurance under the Policy;
b) if such benefits were paid under a Prior Plan;
c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
e) during any Conversion or Portability Period;
f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
g) if requested after insurance under the Policy ends; or
h) if requested after the Policy terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This rider is made a part of group Policy GLUG-1234. It is subject to all of the Policy provisions which are not inconsistent with the provisions of this rider.

This rider is effective the later of October 1, 2016 or the day You become insured under the Policy.

Capitalized terms used in this rider have the meanings assigned to them in this rider or in the other sections of the Policy.

DEFINITIONS

Accident means an external, sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes. Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Accident does include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Intoxicated means having a blood alcohol level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Loss of a Hand or Foot means Severance of at least four whole fingers from one hand or Severance of the foot above the ankle joint.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means total and permanent loss of sight of the eye which cannot be corrected by any means.

Loss of Speech means total and permanent loss of audible communication which cannot be corrected by any means.

Loss of a Thumb and Index Finger means Severance at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing him or her to operate the aircraft.

EXPOSURE AND DISAPPEARANCE

An Insured Person will be presumed to have died, for the purposes of accidental death and dismemberment insurance, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

BENEFITS

Basic Benefits

In the event of a loss while insured under the Policy, We will pay accidental death and dismemberment benefits based upon the amount of the Principal Sum in effect at the time of the loss for You. Benefits for Your insurance will be payable to You or to the beneficiary for life insurance under the Policy.

If an Insured Person is Injured or dies as a result of an Accident, We will pay the benefit shown in the following Table. If an Accident causes more than one loss shown in the Table, We will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table (the "Table")

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum

EXCLUSIONS

We will not pay for any loss which:

a) results, whether the Insured Person is sane or insane, from:
   1. an intentionally self-inflicted Injury or Sickness; or
   2. suicide or attempted suicide;
b) results from the Insured Person's Participation in a Riot or in the commission of a felony;
c) results from an act of declared or undeclared war or armed aggression;
d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
e) is not permanent, unless specifically provided;
f) occurs more than 365 days after the Injury;
g) does not result from an Accident;
h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
i) results from Injuries the Insured Person receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly-scheduled flight or while You are Traveling on Business of the Policyholder;
j) results from an Injury received while riding in any aircraft engaged in:
   1. racing;
   2. endurance tests;
   3. acrobatic or stunt flying;
k) is caused by the Insured Person, and is a result of Injuries received while under the influence of any controlled drug, unless administered on the advice of a Physician;
l) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

Richard C. Anderl

Corporate Secretary

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
ABC Company
123 Street
Omaha, Nebraska 68175

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section and/or Accidental Death and Dismemberment Benefits Rider.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum. Accidental death and dismemberment benefits will be available in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits Rider.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and

d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, and such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If a additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
a) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You or Your Dependent(s).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Annual Earnings means Your gross annual earnings received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder and verified by the premium received by Us.

Your annual earnings include Your contributions to deferred compensation plans.

Your annual earnings do not include commissions, bonuses, overtime pay, other extra compensation, shift differential, or the Policyholder's contributions to deferred compensation plans.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured under the Policy as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) Your divorced, legally separated or former Spouse;
d) a child less than 14 days old;
e) a child who has reached the age of 21, or the age of 25 if a Student, unless the child is Incapacitated;
f) Your married child(ren);
g) Your child if the child has been legally adopted by another person; or
h) a child placed in Your home by a social service agency which retains control over the child.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap.

Injured means the occurrence of an Injury.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2010.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any policy or plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married.

Student means Your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to Us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your means the Employee who is insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made solely by the Policyholder. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The Plan provides coverage for more than one class of Employees.

The benefits under the Plan are fully insured by Us under a group insurance policy issued by Us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 61-1283966
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

ABC Company
123 Street
Omaha, NE 68175
Phone: (402) 123-1234

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

ABC Company
123 Street
Omaha, NE 68175
Phone: (402) 123-1234

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Term Life Benefits

ABC Company

Group Number: G0001234

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

YOUR GROUP VOLUNTARY TERM LIFE BENEFITS

FOR EMPLOYEES OF:

ABC Company

CLASS(ES):

All eligible exempt employees

REVISION EFFECTIVE DATE:

October 1, 2016

PUBLICATION DATE:

September 28, 2016

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF KENTUCKY.

FRAUD WARNING
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Group Number: G000`123

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of You at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Living Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect Your, Your Spouse's or Your family's eligibility for public assistance.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GVTL-1234 (the Policy) has been issued to ABC Company (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Richard C. Anderl
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All eligible exempt employees

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of life insurance from $10,000 to $250,000, in increments of $10,000. In no event shall Your amount of life insurance exceed 5 times Your Annual Earnings, rounded to the next higher multiple of $1,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENT(S)

You may elect to have Your Spouse insured for an amount of life insurance from $5,000 to $50,000, in increments of $5,000, provided the amount elected does not exceed 50% of Your amount of life insurance.

Your Spouse's amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance from $1,000 to $10,000, in increments of $1,000, provided the amount elected does not exceed 50% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

If You have questions regarding the amount of life insurance for Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule. In addition, guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 25% of the eligible Employees, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is 5 times Your Annual Earnings or $250,000, whichever is less, unless You were insured under a Prior Plan. If You were insured under a Prior Plan, Your Guarantee Issue Amount is equal to the amount of insurance that was in-force for You under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Life Insurance for You (the Employee) section of this Schedule.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or $50,000, whichever is less, unless Your Spouse was insured under a Prior Plan. If Your Spouse was insured under a Prior Plan, the Guarantee Issue Amount for Your Spouse is equal to the amount of insurance that was in-force for Your Spouse under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance for Your Spouse stated in the Life Insurance for Your Dependent(s) section of this Schedule.

Guarantee Issue Amount For Your Dependent Child(ren)

The Guarantee Issue Amount for Your Dependent child(ren) is 100% of Your elected amount of life insurance, unless Your Dependent child(ren) were insured under a Prior Plan. If Your Dependent child(ren) were insured under a Prior Plan, the Guarantee Issue Amount for Your Dependent child(ren) is equal to the amount of insurance that was in-force for Your Dependent child(ren) under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum

amount of insurance for Your Dependent child(ren) stated in the Life Insurance for Your Dependent(s) section of this Schedule.

Insurance for You and Your Dependent(s), if applicable, is only available on a guarantee issue basis:

a) during Your First Enrollment Period;
b) during a Subsequent Enrollment Period; or
c) as otherwise stated or allowed in the Policy.

Evidence of Insurability

Evidence of Insurability is required for:

a) insurance elected more than 31 days after the date the Employee or Spouse becomes eligible;
b) any amount of insurance elected in excess of a Guarantee Issue Amount for the Employee or Spouse;
c) any increase in the amount of insurance after the initial election of insurance for the Employee or Spouse, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy;
d) an Employee or Spouse who was eligible for insurance under a Prior Plan but did not elect such insurance; or
e) an Employee or Spouse whose amount of insurance elected under the Policy is in excess of the amount of insurance that was in-force under a Prior Plan the day before the Policy Effective Date, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy.

If Evidence of Insurability is required for items a), d) or e) above, We may require that such evidence be provided at Your expense.

BENEFIT REDUCTIONS

As You grow older, the amount of life insurance for You and Your Spouse will be reduced according to the following schedule:

At the Age of:	The Current Amount of Insurance Will Reduce by:
65	35%
70	25%
75	15%
80	10%

Reductions become effective on the first day of the Policy month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If You are age 65 or older on the date insurance becomes effective, the amount of life insurance for You and Your Spouse will be reduced as shown above. Thereafter, the amount of life insurance will continue to reduce in accord with the schedule above.

If a reduction to Your amount of insurance causes an amount of insurance for one or more of Your Dependents to exceed the maximum amount of insurance described previously in this Schedule, the amount of insurance for the Dependent will be adjusted to comply with the maximum available.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

Actively Working, Active Work means an Employee is performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 30 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed oneself);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function);
f) toileting (the ability to use a restroom); and
g) moving around (as opposed to being bedridden).

Disability Elimination Period means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents; or
c) a significant cost or coverage change under any other employer or group sponsored life plan under which You or Your Dependent(s) are covered.

Partial Disability, Partially Disabled means that, because of an Injury or Sickness lasting longer than 12 months, You are unable to perform the normal duties of Your regular job for the Policyholder on a regular or continuous basis, but are able to satisfy all other requirements of the Active Work definition.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

Total Disability, Totally Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent;

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, neither You nor Your Spouse may elect insurance as a Dependent of the other person.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, both You and Your Spouse may elect insurance for Your Dependent child(ren) under the Policy.

In order to insure an eligible Dependent child, You must insure all of Your eligible Dependent child(ren).

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:

a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not eligible for benefits or continuation of insurance under any provision of the Prior Plan;
d) is not a retired Employee; and
e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:

a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to Us when due; and
e) insurance is subject to any reductions shown in the Schedule and all other terms and conditions of the Policy.

If insurance is provided for the Employee, insurance may also be provided for any eligible Dependent(s).

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision; or
d) the last day of the twelfth month following the Policy Effective Date.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision or the Portability provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Conversion provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

WHEN INSURANCE BEGINS

An eligible Employee must enroll for insurance by submitting a Written Request for insurance for the Employee and any Dependent(s). The Written Request must be submitted to the Policyholder within 31 days following the day the Employee or Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within 31 days following the day the Employee or Dependent(s) become(s) eligible for insurance, the Employee and/or Dependent(s) must provide Evidence of Insurability.

An eligible Employee will become insured on the first day of the month that coincides with or follows the latest of the day:

a) the Employee begins Active Work;
b) the Employee submits a Written Request to enroll for insurance, if applicable; or
c) We approve Evidence of Insurability, if required.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

An eligible Dependent will become insured on the latest of the day:

a) the Employee becomes insured, unless otherwise agreed to by Our authorized representative in Our home office;
b) the Employee acquires the eligible Dependent;
c) the Employee submits a Written Request to enroll the Dependent for insurance, if applicable; or
d) We approve Evidence of Insurability, if required.

An eligible Employee or Dependent must provide Evidence of Insurability if it is required. An eligible Employee or Dependent will become insured for any amount of insurance that requires Evidence of Insurability, including any amount of insurance in excess of the Guarantee Issue Amount (if applicable) for the Employee and any Dependent(s) on the first day of the month that follows the day We approve Evidence of Insurability.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee or Dependent who is:

a) Totally Disabled (with respect to the Employee);
b) confined in a Hospital as an inpatient;
c) confined in any institution or facility other than a Hospital; or
d) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work or Dependent is no longer confined.

Insurance for an Employee who is not Actively Working on the Policy Effective Date due to Injury or Sickness will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day the Dependent has performed all ADLs for at least 15 consecutive days.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 21, or age 25 if a Student, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

THE FIRST ENROLLMENT PERIOD

An Employee may elect insurance for him/herself and any Dependent(s) during the First Enrollment Period.

If an Employee does not elect insurance during the Employee's or Dependent's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

An Employee may elect, drop, increase, decrease or change insurance for the Employee and any Dependent(s) during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance for an Employee or Dependent will require Evidence of Insurability unless otherwise stated or allowed in the Policy.

Life Events

Within 31 days of a Life Event, You may submit a Written Request to change insurance.

If You experience a Life Event and You are currently insured under the Policy, insurance for You and any Dependent(s) may be issued up to the Guarantee Issue Amount without Evidence of Insurability. For any amount of insurance over the Guarantee Issue Amount, or if the Written Request is submitted more than 31 days after the date of a Life Event, We will require Evidence of Insurability.

An Employee who experiences a Life Event who previously declined insurance under the Policy must submit Evidence of Insurability for any change of insurance to be considered by Us.

Annual Increase Option

You may submit a Written Request to increase the amount of insurance once a year, provided the new amount of insurance does not exceed the maximum benefit amount shown in the Schedule. You may increase Your amount of insurance by up to $10,000, in increments as shown in the Schedule.

If the amount of insurance requested exceeds the Guarantee Issue Amount, Evidence of Insurability will be required. If Evidence of Insurability is required for this provision, such evidence will only be required once and will serve as acceptable proof for any future requests to increase the amount of insurance under this provision. This election may be made once a year within a time period designated by the Policyholder and approved by Our authorized representative in Our home office.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your or Your Dependent's class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the date of the request or the change, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended for You and/or Your Dependent(s) in accordance with this provision. You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Work.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date of the Written Request, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to Your non-payment of premium or voluntary termination of insurance, We will require Evidence of Insurability to reinstate insurance.

Transfer From Portability or Conversion

If insurance was obtained under the Portability or Conversion provision while an Employee was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any insurance provided through the Portability provision will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You or any of Your Dependent(s) cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You or any of Your Dependent(s), and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and/or Your Dependent(s) would otherwise end, You and/or Your Dependent(s) may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Injury or Sickness
c) Continuation of Insurance for Partial Disability
d) Continuation of Insurance for Total Disability with Waiver of Premium
e) Portability
f) Conversion

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. end of the month for Your temporary involuntary layoff;
    2. end of the month for Your leave of absence; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision;
c) We receive notification of the approved layoff or leave from the Policyholder within 31 days from the date You cease Active Work; and
d) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Injury or Sickness provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if the following conditions are satisfied:

a) We receive notification of Your Injury or Sickness from the Policyholder within 31 days from the date You cease Active Work or Your insurance would otherwise end; and
b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the day:

a) that is 12 months from the day You cease Active Work;
b) You return to Active Work;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Partial Disability provision, Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision, You may be able to continue insurance under this provision due to Your Partial Disability. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Partially Disabled, but not Totally Disabled;
b) We receive notification of Your Partial Disability from the Policyholder within 31 days from the date You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision; and
c) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the day:

a) You return to Active Work;
b) Your Injury or Sickness results in Your Total Disability and You are eligible to continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your Partial Disability may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance ends under the Continuation of Insurance for Injury or Sickness provision or Continuation of Insurance for Partial Disability provision, You may be able to continue insurance under this provision due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 9 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Totally Disabled;
b) You were under age 60 at the time You became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

Insurance may only be continued for You. If You are able to continue insurance under this provision, Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

If You are age 60 or older and become Totally Disabled, You and Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 9 consecutive months. Any period of time in which You are insured under the Continuation of Insurance for Injury or Sickness provision will apply toward satisfaction of the Disability Elimination Period.

Proof of Total Disability

You must submit to Us acceptable proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at Your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You and Your Dependent(s) will have 31 days from the date of Our notice to submit a Written Request for insurance under the Portability or Conversion provision, if You have not returned to Active Work or You are not eligible for insurance under the Continuation of Insurance for Partial Disability provision.

When Insurance Under this Provision Ends

Insurance under this provision will end on the day:

a) You are eligible to continue insurance under the Continuation of Insurance for Partial Disability provision; or
b) You return to Active Work.

Insurance under this provision will also end on the earliest of the day:

a) You are no longer Totally Disabled;
b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
d) You reach age 65; or
e) You begin full-time employment with an employer other than the Policyholder.

Insurance under this provision will also end in accordance with the Grace Period provision.

PORTABILITY

You have the right to continue receiving group life insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment with the Policyholder ends; or
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

In addition to the above reasons, Your Spouse has the right to continue receiving group insurance, including insurance for Dependent child(ren), under this provision if Your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:

a) You reach the Attained Age of 70, but Your Spouse is under age 70;
b) You continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
d) divorce or legal separation of You and Your Spouse; or
e) Your death.

If Your Spouse continues to receive insurance under this provision, Dependent child(ren) may be insured under You or Your Spouse, but not both.

If You are eligible for insurance under this provision and You are not eligible for insurance under any other continuation provision of the Policy (if applicable), You must continue insurance under this provision in order for Your Dependent(s) to be eligible.

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance for each Insured Person shall not exceed the lesser of:

a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000 for You and $250,000 for Your Dependents.

The amount of insurance may not be increased after insurance continues under this provision.

If You continue to receive group insurance under this provision, You and Your Dependent(s) can not continue insurance under any other continuation provision of the Policy (if applicable).

The Group Term Life Insurance Portability Policy

Group insurance continued under this provision is available under another group term life insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You or Your Spouse become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy ends ("Portability Period"). When insurance under the Policy ends, notice of the right to continue receiving insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to apply for a Portability Policy will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Continue Group Insurance Under this Provision

You or Your Spouse must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance.

When Employment or Class Membership Ends or the Amount of Insurance Reduces

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy"). If group life insurance for any of Your Dependent(s) ends or reduces due to Your death, divorce, legal separation or failure to satisfy any other eligibility condition, Your Dependent(s) may also apply for a Conversion Policy.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You and/or Your Dependent(s) may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits;
c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If You or any of Your Dependent(s) are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You or Your Dependent(s) did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or Your Dependent(s) must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If You or any of Your Dependent(s) are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premiums for insurance for You and/or Your Dependent(s) under the Policy. The premium owed by You equals the total premium for all Insured Person(s).

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us, as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 31 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance for You and/or Your Dependent(s) will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for You and/or Your Dependent(s) will terminate during the grace period. If We receive such notice, insurance will terminate for You and/or Your Dependent(s) on the date requested.

If any premium due is not paid during the grace period, insurance for You and/or Your Dependent(s) will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance for You and/or Your Dependent(s), the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for You and/or Your Dependent(s) in accordance with the terms of the Policy, or a change in the amount of insurance for You and/or Your Dependent(s) as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach the Attained Age of the next higher age band in the premium rate structure for the Policy; or
b) You reach an Attained Age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
c) premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You or any of Your Dependent(s), if applicable. Benefits payable by reason of Your death will be paid to Your beneficiary. Benefits payable by reason of the death of Your Dependent(s), if applicable, will be paid to You.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

a) Your surviving Spouse; if none, then to
b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
c) Your surviving parent(s), in equal shares; if none, then to
d) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

You are the beneficiary of Your Dependent(s) benefits. If You are not living at the time of the death of any of Your Dependent(s), the following will apply:

a) In the event of the death of Your Spouse, benefits will be paid to Your Spouse's estate.
b) In the event of the death of any of Your Dependent child(ren), benefits will be paid to Your Spouse, if Your Spouse is living. If Your Spouse is not living, benefits will be paid in equal shares to the deceased child's living siblings. If there are no living siblings, benefits will be paid to the estate of the deceased child.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

FACILITY OF PAYMENT

We may pay an amount of up to $2,000 to any person or entity that has incurred expenses related to Your death and subsequent burial, or to the death and subsequent burial of any of Your Dependent(s), if applicable. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIFE INSURANCE BENEFITS EXCLUSION

We will not pay benefits for a death which results from suicide, while sane or insane, within two years from the date insurance begins (under the Policy or any Prior Plan). Instead, We will refund the total of the premiums paid for insurance under the Policy.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of insurance under the Policy, benefits in the amount of the increase will not be paid. Instead, We will refund the total of the premiums paid under the Policy for said increase in insurance.

LIVING BENEFITS (ACCELERATED BENEFIT)

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting Living Benefits.

DEFINITIONS

Living Benefits means an advance payment of part of Your life insurance death benefit.

Terminal Condition means an Injury or Sickness that is expected to result in Your death within the next 12 months as certified by an attending Physician's written statement.

ABOUT LIVING BENEFITS

If You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or $187,500, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or $1,000, whichever is greater.

We will pay Living Benefits to You in a lump sum, provided You are living at the time payment is made.

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You. Life insurance on other Insured Persons, if any, is not affected by payment of Living Benefits for You.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, You, Your Spouse or Your legal representative must provide Us:

a) a Written Request for Living Benefits;
b) satisfactory proof of Your Terminal Condition, including an attending Physician's written statement; and
c) a statement of consent from any beneficiary(ies) or assignee(s).

You, Your Spouse or Your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for You only once under the Policy;
b) You can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) Premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You; and
e) The Portability provision is not available for You after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when You have irrevocably assigned life insurance under the Policy;
b) if such benefits were paid under a Prior Plan;
c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
e) during any Conversion or Portability Period;
f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
g) if requested after insurance under the Policy ends; or
h) if requested after the Policy terminates.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
ABC Company
123 Street
Omaha, Nebraska 68175

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, and such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If a additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
a) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You or Your Dependent(s).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Annual Earnings means Your gross annual earnings received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder and verified by the premium received by Us.

Your annual earnings include Your contributions to deferred compensation plans.

Your annual earnings do not include commissions, bonuses, overtime pay, other extra compensation, shift differential, or the Policyholder's contributions to deferred compensation plans.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on January 1, 2017 and the Policy Anniversary is October 1, the Insured Person will reach the attained age of 50 on October 1, 2017.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured under the Policy as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) Your divorced, legally separated or former Spouse;
d) Your Spouse after You reach the Attained Age of 70;
e) a child less than 14 days old;
f) a child who has reached the age of 21, or the age of 25 if a Student, unless the child is Incapacitated;
g) Your married child(ren);
h) Your child if the child has been legally adopted by another person; or
i) a child placed in Your home by a social service agency which retains control over the child.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

First Enrollment Period means the 31-day period following the day the Employee or Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Guarantee Issue Amount means the amount of life insurance We may issue without requiring Evidence of Insurability.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2010.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any policy or plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married.

Student means Your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to Us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your means the Employee who is insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made solely by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The Plan provides coverage for more than one class of Employees.

The benefits under the Plan are fully insured by Us under a group insurance policy issued by Us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 61-1283966
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

ABC Company
123 Street
Omaha, NE 68175
Phone: (402) 123-1234

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

ABC Company
123 Street
Omaha, NE 68175
Phone: (402) 123-1234

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Marketing Reporting Package

GROUP WEB REPORTING USER GUIDE

This user guide describes the information available through Mutual of Omaha's Group Web Reporting. Many of the standard and on-demand reports can be requested on a 24x7 basis. (The return time of the on-demand reports vary) Please keep the following in mind, when analyzing report results:

- **There will be differences in results shown on Claims Experience reports as compared to Financial reports. The integrity and purpose of each type of report is accurate, but, the distinct nature and objective of each report type doesn't allow for comparative accuracy.**

For general questions or for specific questions on the results of the report output, please contact your Mutual of Omaha service representative.

GROUP WEB REPORTING
Financial User Guide

On-Demand Financial Reports

On-Demand reports are prepared and delivered to you at your request. This unique report delivery option provides our customers with the opportunity to enter specific report parameters within the request. In a short time span, usually within 15 – 30 minutes, an email with a link to the report is sent to the requestor. The format of the reports is either in Excel or PDF.

The types of reports you have access to depend on the products purchased.

GROUP WEB REPORTING
Financial On-Demand Reports

- **Paid Basis**
- **Issued Payment Analysis Tool**

PAID BASIS

Customer Report Guide

Electronically demonstrate, in Financial terms and representative of Financial Systems, some high-level premium and claim data that ties to accounting periods. Multiple pages are represented for each product. (i.e. Health, Dental, Stop Loss, Disability, etc.) The file type for this report is that of an un-editable Adobe (PDF) file.

User Defined Criteria:

From Month, Year
To Month, Year

Uses:

- Originally designed as an internal report, some customers have found certain premium and claims aspects of this report useful. The ability to run the report with user-defined dates has been deemed very useful.

Limitations:

- Since it was designed as an internal report, it may not be in the most user-friendly format.
- The report should never be used to balance with claims and experience reports. Financial data record-keeping is associated with hard accounting close dates. This is opposed to experience reporting which is, by nature, always evolving with adjustments and other factors.

Mutual of Omaha
Regular Paid Basis (BIM0059)

G000XXXX ABC Inc.
Period: 01/01/2004 to 07/01/2004
Run Date: 07/28/2004

		HEALTH					LIFE						AD&D	
Policy	Date	Enrollment Count	Premium	Paid Claims	Draft Count	Claim Ratio	Enrollment Count	Premium	Paid Claims	Draft Count	Life Claim Ratio	Combined Ratio	Premium	Claims
GLUG0XXXX	2004/01/01	574	$0	$0	0	0	574	$1,983	$0	0	0.0	0.0	$551	$0
GLUG0XXXX	2004/02/01	576	$0	$0	0	0	576	$1,994	$0	0	0.0	0.0	$554	$0
GLUG0XXXX	2004/03/01	572	$0	$0	0	0	572	$1,975	$0	0	0.0	0.0	$549	$0
GLUG0XXXX	2004/04/01	570	$0	$0	0	0	570	$1,965	$0	0	0.0	0.0	$546	$0
GLUG0XXXX	2004/05/01	569	$0	$0	0	0	569	$1,938	$0	0	0.0	0.0	$538	$0
GLUG0XXXX	2004/06/01	569	$0	$0	0	0	569	$1,938	$0	0	0.0	0.0	$538	$0
GLUG0XXXX Total			$0	$0	0			$11,793	$0	0			$3,276	$0
GVTL0XXXX	2004/01/01	0	$0	$0	0	0	355	$7,574	$0	0	0.0	0.0	$0	$0
GVTL0XXXX	2004/02/01	0	$0	$0	0	0	358	$7,563	$0	0	0.0	0.0	$0	$0
GVTL0XXXX	2004/03/01	0	$0	$0	0	0	356	$7,582	$0	0	0.0	0.0	$0	$0
GVTL0XXXX	2004/04/01	0	$0	$0	0	0	351	$7,468	$0	0	0.0	0.0	$0	$0
GVTL0XXXX	2004/05/01	0	$0	$0	0	0	354	$7,497	$0	0	0.0	0.0	$0	$0
GVTL0XXXX	2004/06/01	0	$0	$0	0	0	354	$7,497	$0	0	0.0	0.0	$0	$0
GVTL0XXXX Total			$0	$0	0			$45,181	$0	0			$0	$0
UP 0XXXX	2004/01/01	430	$10,240	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX	2004/02/01	445	$10,459	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX	2004/03/01	444	$10,326	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX	2004/04/01	449	$10,589	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX	2004/05/01	447	$10,585	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX	2004/06/01	444	$10,323	$0	0	0	0	$0	$0	0	0.0	0.0	$0	$0
UP 0XXXX Total			$62,522	$0	0			$0	$0	0			$0	$0
Grand Total			$62,522	$0	0			$56,974	$0	0			$3,276	$0

ISSUED PAYMENT ANALYSIS TOOL

Customer Report Guide

This financial report provides summarized and line-item detail of all the financial transactions to the bank account. At the summary level, our customers can analyze paid claim information at the Department, Location, and Class levels. Due to the user-friendly pivot table functionality, a customer can filter the information by a variety of Product, Time Period, and Policy levels. The detail tab includes a wealth of line-item detail, should the customer want to analyze it at that level.

User Defined Criteria:

From Month, Year
To Month, Year

Uses:

- Customers can see electronic summarization of financial transactions related to the bank account activity. Since the results are presented in an Excel Pivot table, they have a variety of different ways to segment and analyze the results. This includes the ability to look at the data for given month or year time periods.

Limitations:

- The report should never be used to balance with claims and experience reports. The data represents bank account activity only. This is opposed to experience reporting which is, by nature, always evolving with adjustments and other factors

Mutual of Omaha
Issued Payment Analysis (BIM0064)
G000XXXX ABC Inc.
Accounting Dates: 06/01/2004 to 07/01/2004

PRODUCT	(All)
TRANS_TYPE	(All)
ACCT_YEAR	(All)
ACCT_MONTH	(All)
SERIES	(All)
POLICY	(All)

PAYMENT AMOUNT		CLASS				
DEPARTMENT	LOCATION	A001	A002	C001	C001	Grand Total
01	01	$85.00			$235.00	$320.00
	01	$39,655.00	$13,060.00	$162.00		$52,877.00
	02	$34,512.00				$34,512.00
	03	$16,930.00		$100.00		$17,030.00
	04	$199.00				$199.00
	04	$11,745.00		$310.00		$12,055.00
	05	$7,218.00		$72.00		$7,290.00
	06	$2,014.00		$108.00		$2,122.00
	07	$952.00		$112.00		$1,064.00
	08	$2,039.00	$322.00	$362.00	$462.00	$3,185.00
	09	$2,011.00				$2,011.00
	10	$2,698.00				$2,698.00
02	01			$893.00	$2,403.00	$3,296.00
	03	$718.00		$11,955.00		$12,673.00
	04			$676.00		$676.00
	05	$55,500.00				$55,500.00
	06	$39,230.00				$39,230.00
	07	$27,382.00		$2,647.00		$30,029.00
	08	$7,244.00		$75.00		$7,319.00
	09	$15,619.00		$85.00		$15,704.00
	10	$2,618.00		$0.00		$2,618.00
Grand Total		$268,369.00	$13,382.00	$17,557.00	$3,100.00	$302,408.00

*Includes both payments and refund data.

GROUP WEB REPORTING
Disability User Guide

On-Demand Disability Reports

On-Demand reports are prepared and delivered to you at your request. This unique report delivery option provides our customers with the opportunity to enter specific report parameters within the request. In a short time span, usually within 15 – 30 minutes, an email with a link to the report is sent to the requestor. The format of the reports is either in Excel or PDF.

The types of reports you have access to depend on the products purchased.

GROUP WEB REPORTING
Disability On-Demand Reports

- **STD Reports**
- **LTD Reports**
- **STD/ATP Reports**
- **LTD/ATP Reports**

GROUP WEB REPORTING
Short-Term Disability On-Demand Reports

Mutual of Omaha

- **Paid Claims**
- **Pended Claims**
- **Termed Claims**
- **New/Active/Term Cases**
- **New/Active Cases**
- **Managed Claim Report**
- **Claim Cost Summary**
- **Period to Period**

SHORT-TERM DISABILITY PAID CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been paid a disability benefit
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Estimated return to work dates (Physician's recommendation or the Mutual of Omaha Companies disability duration guideline, whichever is lesser)
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Sum of benefit checks issued for the stated period, after offsets, prior to tax deductions
- Paid dates (range of time from which benefits were paid in the stated period)

Uses:

- Provides a comprehensive view of paid claims.
- Allows Policyholder to verify accuracy and timeliness of benefit payments.
- Assists with salary continuation planning and/or payment.
- Identifies whether temporary help will need to be hired, based on estimated return-to-work date.

Limitations:

- The estimated return to work date may fluctuate based on the claimant's disability. If no date appears, then the claimant has either been terminated (see terminated report), an estimated return-to-work date has not been established or the disability may be so severe that the claimant is not expected to return to work.
- A claimant may appear on the paid and terminated reports if the claimant was paid and terminated in the same reporting period.
- If the estimated return-to-work date equals the benefit expiration date, then either the claimant is not expected to return to work or it is anticipated that the disability will run the maximum benefit duration, as stated in the policy.

Short-Term Disability Paid Claims (BIM0040)

G000XXXX: ABC Inc.
Period: 06/11/2004 to 07/17/2004
Run Date: 07/20/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Estimated Return to Work	Benefit Expiration Date	Gross Benefit Amount	Paid Dates
GUSISXXXX	2A	AMMER/JOYCE	123456789	10/18/1962	06/10/2004	06/10/2004	06/15/2004	12/09/2004	$98.20	06/10/2004 - 06/15/2004
GUSISXXXX	2A	AULTHOUSE/ALVA	234567890	01/20/1945	01/06/2004	01/13/2004	08/16/2004	01/11/2005	$825.00	06/09/2004 - 07/14/2004
GUSISXXXX	2A	BRAUN/LONNIE	345678901	04/17/1945	06/23/2004	06/23/2004	09/13/2004	12/22/2004	$636.42	06/23/2004 - 07/20/2004
	2A Total								$1,559.62	
GUSISXXXX	4A	HEIT/LORRIE	456789012	09/10/1965	05/12/2004	05/19/2004	N/A	11/17/2004	$1,000.00	06/09/2004 - 07/14/2004
GUSISXXXX	4A	JOHN/DORIS	567890123	08/04/1955	04/27/2004	04/27/2004	N/A	10/26/2004	$1,000.00	06/08/2004 - 07/13/2004
GUSISXXXX Total									$3,559.62	
	Grand Total								$3,559.62	
Grand Total									$3,559.62	

SHORT-TERM DISABILITY PENDED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have filed a disability claim
- Benefit amounts (prior to any tax deductions, less offsets), if available
- Reasons pended:
  - Awaiting entire claim form means all parts of the three-part claim form have not been received.
  - Awaiting disability decision means the case is under review and a decision has not yet been made.

Uses:

- Provides a concise view of pended claims on a monthly basis.

Additional Information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Short-Term Disability Pended Claims (BIM0045)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/15/2004
Run Date: 07/15/2004

Policy	Dept	CertName	CertNum	DOB	Date of Disability	Gross Benefit Amount	Reason Pended
GUG 0XXXX	1A	BRODY/ABE	123456789	08/12/1957	04/28/2004	$100.00	AWAITING DISABILITY DECISION
GUG 0XXXX	1A	REDINGTON/LAWYER	234567890	04/30/1947	05/07/2004	$250.00	AWAITING DISABILITY DECISION
	1A Total					$350.00	
GUG 0XXXX Total						$350.00	
	Grand Total					$350.00	
Grand Total						$350.00	

SHORT-TERM DISABILITY TERMED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been terminated from receiving additional disability benefits
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Benefit termination dates
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Reasons terminated:
  - * Released – never returned to work
  - * Offsets exceeds benefit amount
  - * Claim incomplete or withdrawn
  - * Passed away
  - * Met age limit or ADEA benefit
  - * Returned to work
  - * Not totally disabled – own occupation
  - * Current earnings not received
  - * Ineligible or policy exclusion
  - * Did not exceed elimination period
  - * Transferred to Long-Term Disability
  - * Not totally disabled – any occupation
  - * Rehabilitation settlement
  - * Settlement
  - * Advanced benefit settlement
  - * Proof of disability not received
  - * Reached maximum benefit

Uses:

- Provides a comprehensive view of terminated claims.

Limitations:

- A claimant may appear on the authorized and terminated reports if the claimant was authorized and terminated in the same reporting period.

Additional information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Short-Term Disability Termed Claims (BIM0049)

G000XXXX: ABC Inc.
Period: 09/01/2002 to 06/01/2004
Run Date: 06/18/2004

Mutual of Omaha

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Benefit Term Date	Benefit Expire Date	Total Paid	Reason Terminated
GUC 0XXXX	1	BOWLS/BRAD	123456789	09/19/1953	04/01/2004	04/15/2004	05/13/2004	09/30/2004	$2,616.00	NOT TOTALLY DISABLED - OWN OCC
GUC 0XXXX	1	WANDER/LOUISE	234567890	08/05/1966	03/11/2004	03/25/2004	04/22/2004	09/09/2004	$2,327.84	NOT TOTALLY DISABLED - OWN OCC
GUC 0XXXX	1	TUCK/ALLY	345678901	09/16/1971	01/21/2004	02/04/2004	01/21/2004	01/21/2004	$1,631.91	CLAIM INCOMPLETE OR WITHDRAWN
GUC 0XXXX	1	VAN HIEMMERIK/JORDAN	456789012	08/04/1977	02/25/2004	03/10/2004	04/06/2004	09/10/2004	$2,009.25	NOT TOTALLY DISABLED - OWN OCC
	1 Total								$8,585.00	
GUC 082S8 Total									$8,585.00	
GUG 0XXXX	1	BLAIR/ROSIE	567890123	06/18/1964	12/09/2003	12/23/2003	01/22/2004	06/08/2004	$4,559.14	NOT TOTALLY DISABLED - OWN OCC
GUG 0XXXX	1	BROWN/TOM	678901234	05/18/1949	03/11/2003	03/25/2003	06/21/2003	09/09/2003	$5,915.98	PASSED AWAY
	1 Total								$10,475.12	
GUG 0XXXX Total									$10,475.12	
	Grand Total								$19,060.12	
Grand Total									$19,060.12	

Short-Term Disability New-Active-Term Case Summary (BIM0053)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 06/23/2004
Run Date: 06/23/2004

Policy	Year	Month	New Cases	Active Cases	Term Cases
GUG 081D4	2004	1	4	10	2
GUG 081D4	2004	2	5	22	2
GUG 081D4	2004	3	1	27	4
GUG 081D4	2004	4	4	35	2
GUG 081D4	2004	5	1	28	5
GUG 081D4	2004	6	4	26	4

Short-Term Disability New-Active Cases (BIM0057)

G000XXXX: ABC Inc.
Period: 05/01/2004 to 07/07/2004
Run Date: 07/07/2004

Mutual of Omaha

Policy	Employee	Address	Address2	City	State	ZIP	SSN	DOB	Gender	LDW		
GUC 0XXXX	BRIDGE/NIKKI	SUMMERSET LANE		AUDUBON	IA	56511	123456789	02/10/1978	F	04/23/2004		
GUC 0XXXX	VASEU/NATE	920 COUNTRY RD		FARGO	NE	58103	234567890	03/13/1972	F	03/22/2004		
GUC 0XXXX Count	2											
Grand Count	2											

SHORT-TERM DISABILITY MANAGED CLAIM REPORT

Customer Report Guide

This report identifies and quantifies the results of Mutual of Omaha's Short-Term Disability claims management for a policyholder.

- 'Number of Claims' is the number of STD claims that have been closed during the reporting period.
- 'Non-Managed Disability Days' is the total of days submitted for STD benefit payment under the policy.
- 'Managed Disability Days' is the sum total of days considered and paid for STD benefit payments.
- 'Disability Days Saved' is the difference between 'Managed Disability Days' and 'Non-Managed Disability Days'
- 'Calculated Benefits Saved' equals (Disability Days Saved) multiplied by (STD benefit based on daily rate).

Uses:

- The policyholder is able to utilize this report to gauge effectiveness of a Managed Disability program, and to track and monitor time and productivity metrics.

Limitations:

- This report does not include all short-term disability claims received. The claims used for this report are closed (benefits have been paid and the employee is no longer on short-term disability). At the time a claim is closed is when days saved and benefits saved can be calculated.

Short Term Disability
Managed Claim Report
G000XXXX ABC Inc.
Period: 01/01/2003 to 01/01/2004

Policy	Dept	Diagnostic Category	Number of Claims	Non-Managed Disability Days	Managed Disability Days	Disability Days Saved	Calculated Benefits Saved
GLLP0XXXX	1A	ACCIDENT	12	539	501	38	$5,938
GLLP0XXXX	1A	CANCER	26	1096	909	187	$68,276
GLLP0XXXX	1A	CARDIO-RESPIRATORY	34	801	686	115	$29,675
GLLP0XXXX	1A	DIGESTIVE	27	239	183	56	$36,118
GLLP0XXXX	1A	GENITO-URINARY	14	150	135	15	$1,777
GLLP0XXXX	1A	MATERNITY	12	198	198	0	$0
GLLP0XXXX	1A	MENTAL ILLNESS	5	388	377	11	$1,144
GLLP0XXXX	1A	MUSCULOSKELETAL	32	1442	1,237	205	$88,649
GLLP0XXXX	1A	NERVOUS SYSTEM	14	391	361	30	$4,851
GLLP0XXXX	1A	OTHER	34	584	421	163	$76,199
GLLP0XXXX	1A	UNDEFINED	6	44	24	20	$2,074
	1A Total		216	5872	5,032	840	$314,701
GLLP0XXXX Total			216	5872	5,032	840	$314,701
GUG 0XXXX	1	ACCIDENT	1	0	0	0	$0
GUG 0XXXX	1	DIGESTIVE	1	0	0	0	$0
GUG 0XXXX	1	MUSCULOSKELETAL	1	5	5	0	$0
	1 Total		3	5	5	0	$0
GUG 0XXXX Total			3	5	5	0	$0
	Grand Total		219	5877	5,037	840	$314,701
Grand Total			219	5877	5,037	840	$314,701

SHORT-TERM DISABILITY CLAIM COST SUMMARY

Customer Report Guide

This report identifies total STD disability days paid, average days paid per STD claim, total work-days lost due to short term disabilities, average work-days lost per claim, total benefit dollars paid and the average cost per STD claim.

- 'Number of Claims Received' is the number of STD claims received by Mutual of Omaha during the reporting period.
- 'Total Days Lost' is the sum total of all days that claimants were not at work due to disability for the reporting period. This total includes the STD elimination period.
- 'Total Days Paid' is the sum total of all days that claimants were not at work due to disability for the reporting period. This total excludes the STD elimination period.
- 'Total Benefit Dollars Paid' is the sum total of all STD benefit dollars paid to all STD claimants during the reporting period.
- 'Average Benefit Dollars per Claim' is the 'Total Benefit Dollars Paid' divided by the 'Number of Claims Received' during the reporting period.
- 'Average Days Paid per Claim' is the number of average number of days claimants were in receipt of STD benefit payments.
- 'Average Days Lost per Claim' is the number of average number of days claimants were not at work due to Short-Term Disability injury or sickness.

Uses:

- The policyholder can use this report to identify trends in STD program costs and to compare STD benefit costs over several reporting periods. The policyholder can also use this report to assist with tracking and monitoring of productivity and lost-time metrics.

Short Term Disability
Claim Cost Summary
G000XXXX ABC Inc.
Period: 01/01/2003 to 01/01/2004

Mutual of Omaha

Policy	Number of Claims Received	Total Days Lost*	Total Days Paid	Total Benefit Dollars Paid	Average Benefit Dollars per Claim	Average Days Paid per Claim	Average Days Lost per Claim*
GLLP0XXXX	189	7,088	5,959	$622,088	$3,291	32	38
GUG 0XXXX	11	913	807	$88,336	$8,031	73	83

* Data includes STD elimination period.

BIM0062

SHORT-TERM DISABILITY

Customer Report Guide

These claim reports are useful claims management tools for Mutual of Omaha's group Short-Term Disability policyholders who are experiencing a high level of claims activity, or with at least 200 employees insured under the group. These reports are to be used as a claims management reporting tool for our policyholders, and are not intended for use in the determination of establishing pricing levels or future expected claims levels. All reported claim amounts are paid claims only, and do not reflect future claims liability, nor do any of these reports reflect Incurred But Not Reported reserves.

Please contact your Mutual of Omaha Group Sales Office for additional details.

"Paid Claims by Cause" – Current vs Prior Period (BIM0067-A)

This report identifies STD claims by cause (accident, illness and maternity) and compares the claims results from one period to another.

Purpose:
This report allows the user to identify if there is a higher proportion of claims in certain general categories, and to identify year-to-year trends in claims patterns.

"Distribution of STD Paid Claims by Cause" – Current vs Prior Period (BIM0067-B)

This report identifies the group's distribution of the number of STD claims by cause, and compares the results from one period to another.

Purpose:
This report allows the user to identify the general categories under which STD claims are being incurred under the group. The user is able to identify if there are emerging trends and to take corrective actions.

"Claim Incidence Rate by Cause" – Current vs Prior Period (BIM0067-C)

This report identifies the group's STD claim incidence rates over different reporting periods. The claim incidence rate is the number of STD claims incurred "per 1,000" employees.

Purpose:
This report allows the user to identify emerging trends in the incidence rate for accidents, maternity, or illness.

"Average Paid Claims by Cause" – Current vs Prior Period (BIM0067-D)

This report identifies the average cost for each STD claim incurred under the group over different reporting periods.

Purpose:
This report allows the user to determine if there are shifts in the average cost of STD claims, and to take corrective action if necessary.

"Average Claim Duration by Cause" – Current vs Prior Period (BIM0067-E)

This report identifies the average STD claim duration across broad categories between different reporting periods. Average claim durations are measured from the date of disability to the date of claim termination.

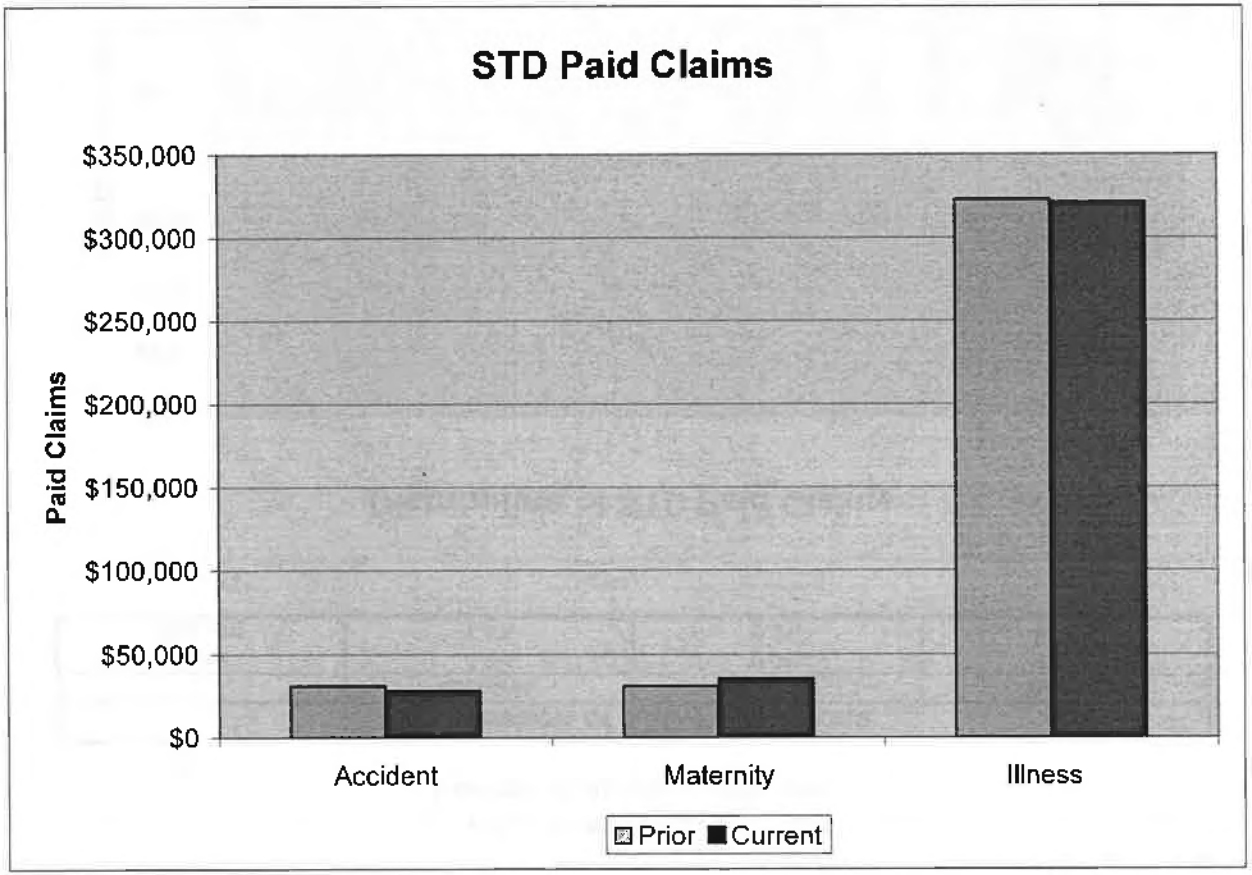
Purpose:
This report allows the user to determine if there are shifts in the average duration of STD claims, and to take corrective action if necessary.

Short Term Disability
Paid Claims by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Short Term Disability Paid Claims				
	Accident	Maternity	Illness	Total
Prior	$30,947.97	$30,846.00	$322,888.00	$384,681.97
Current	$27,912.00	$35,266.00	$321,184.83	$384,362.83



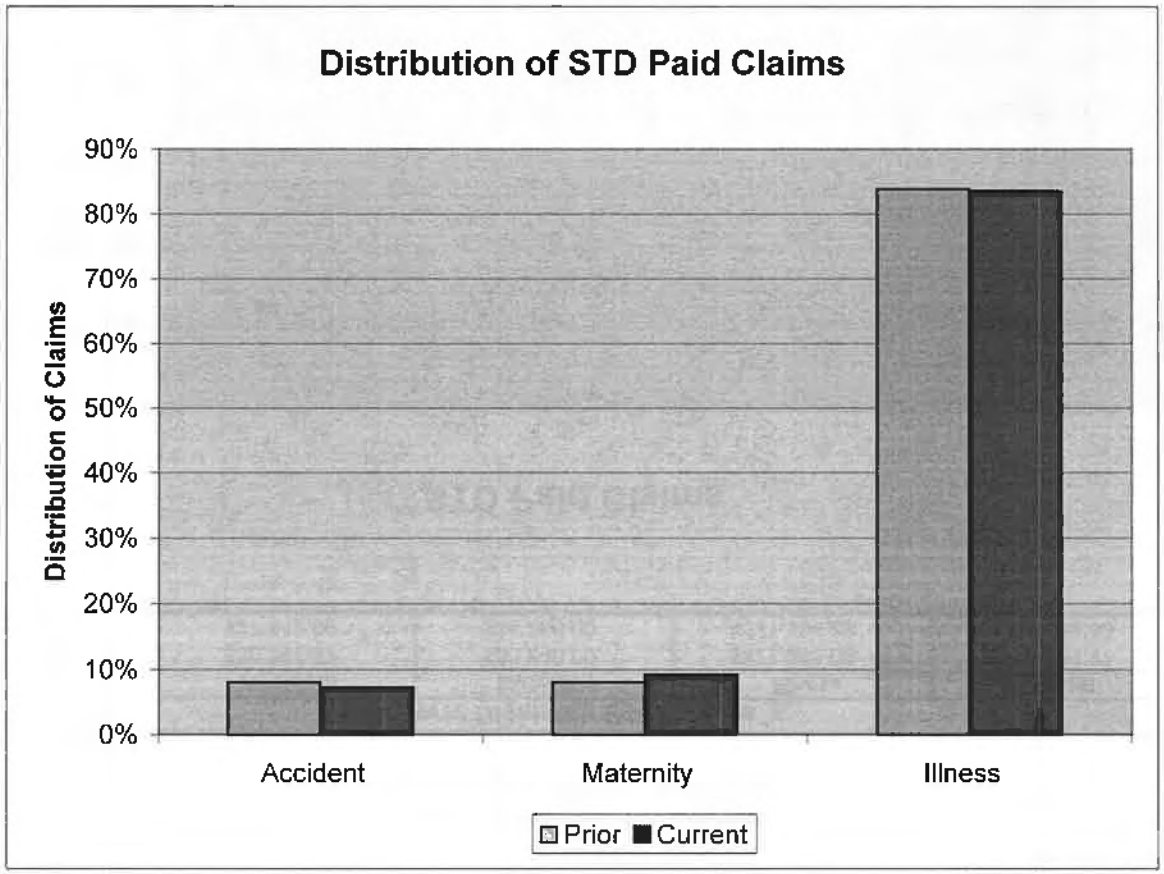
BIM0067-A

Short Term Disability
Distribution of Paid Claims by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

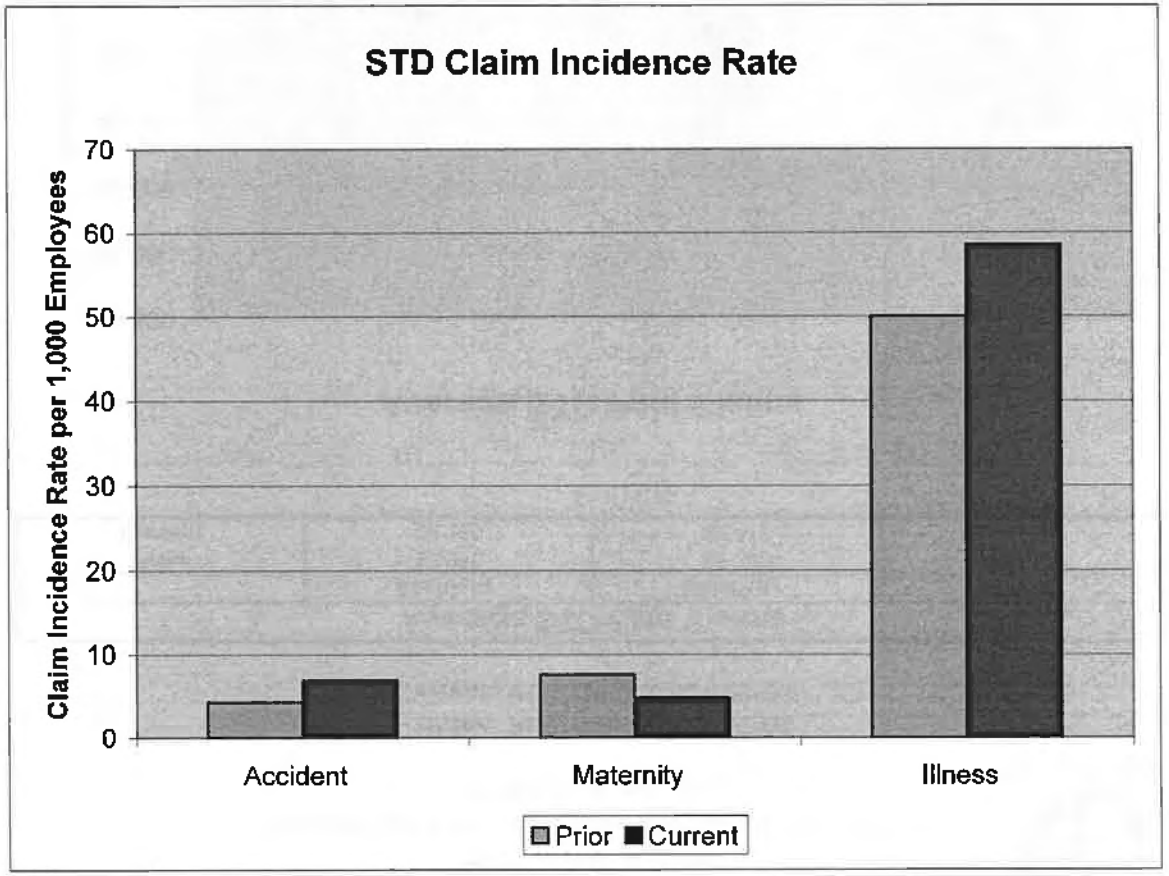
Distribution of STD Paid Claims			
	Accident	Maternity	Illness
Prior	8.0%	8.0%	83.9%
Current	7.3%	9.2%	83.6%



Short Term Disability
Claim Incidence Rate by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

STD Claim Incidence Rate (per 1,000 covered employees)			
	Accident	Maternity	Illness
Prior	4.3	7.6	50.0
Current	6.9	4.8	58.5



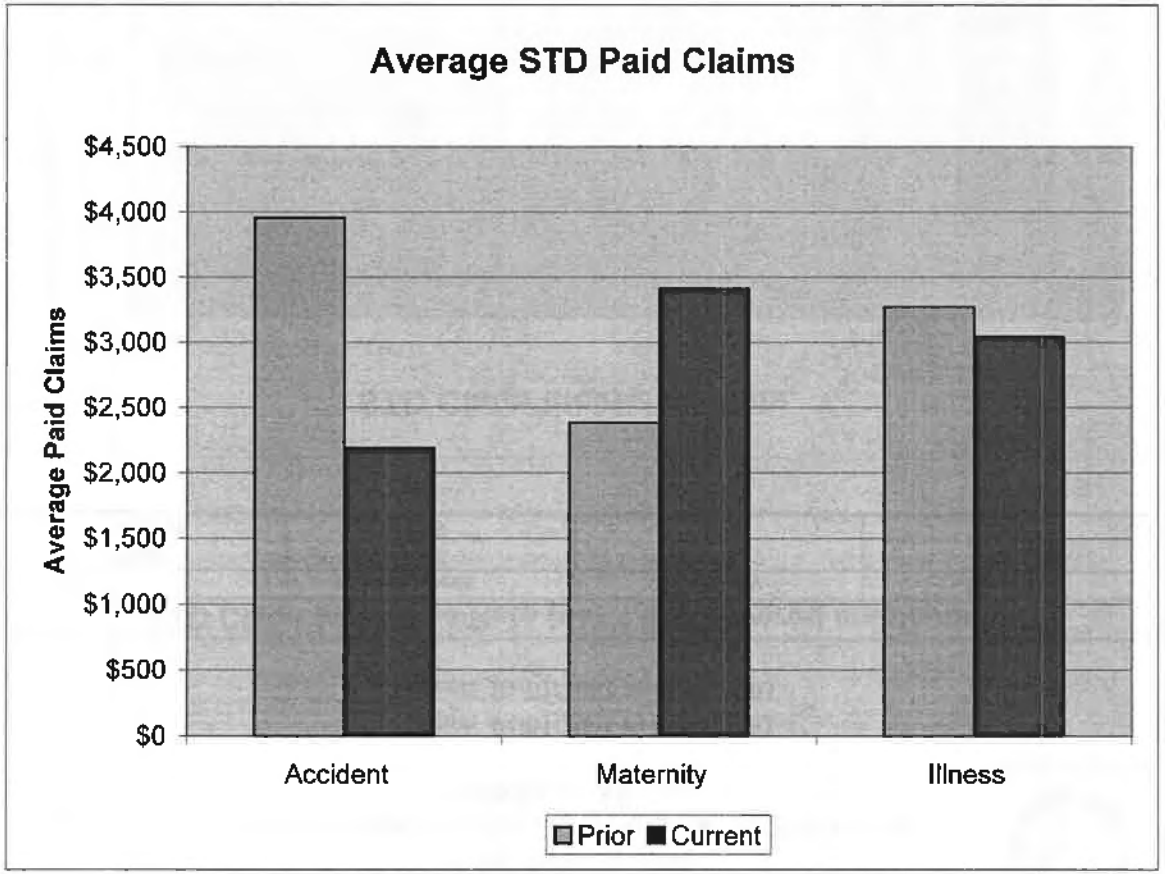
BIM0067-C

Short Term Disability
Average Paid Claims by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Average STD Paid Claims			
	Accident	Maternity	Illness
Prior	$3,955	$2,382	$3,272
Current	$2,190	$3,412	$3,044



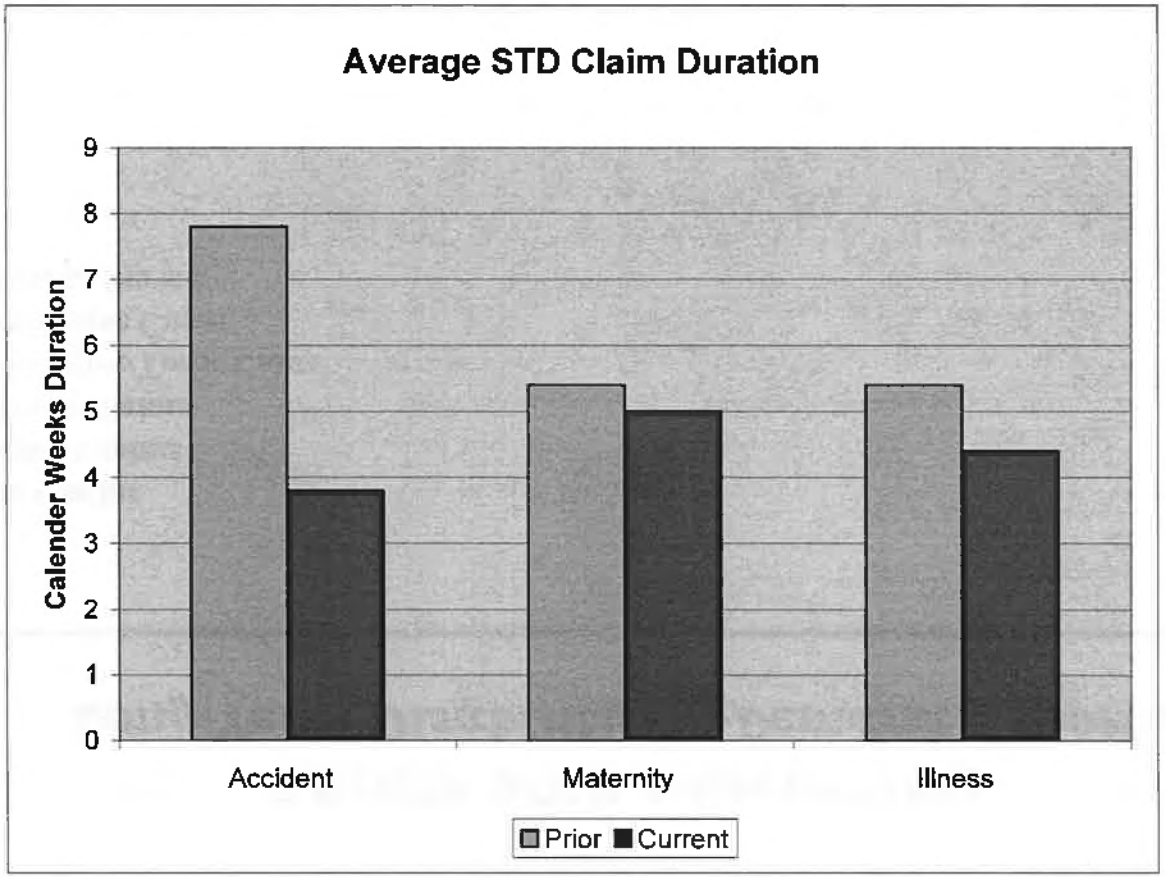
BIM0067-D

Short Term Disability
Average Claim Duration by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Average STD Claim Duration (weeks)			
	Accident	Maternity	Illness
Prior	7.8	5.4	5.4
Current	3.8	5.0	4.4



BIM0067-E

GROUP WEB REPORTING
Long-Term Disability On-Demand Reports

Mutual of Omaha

- **Paid Claims**
- **Pended Claims**
- **Termed Claims**
- **New/Active/Term Cases**
- **New/Active Cases**
- **Period to Period**

LONG-TERM DISABILITY PAID CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been paid a disability benefit
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Estimated return to work dates (Physician's recommendation or the Mutual of Omaha Companies disability duration guideline, whichever is lesser)
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Sum of benefit checks issued for the stated period, after offsets, prior to tax deductions
- Paid dates (range of time from which benefits were paid in the stated period)

Uses:

- Provides a comprehensive view of paid claims.
- Allows Policyholder to verify accuracy and timeliness of benefit payments.
- Assists with salary continuation planning and/or payment.
- Identifies whether temporary help will need to be hired, based on estimated return-to-work date.

Limitations:

- The estimated return to work date may fluctuate based on the claimant's disability. If no date appears, then the claimant has either been terminated (see terminated report), an estimated return-to-work date has not been established or the disability may be so severe that the claimant is not expected to return to work.
- A claimant may appear on the paid and terminated reports if the claimant was paid and terminated in the same reporting period.
- If the estimated return-to-work date equals the benefit expiration date, then either the claimant is not expected to return to work or it is anticipated that the disability will run the maximum benefit duration, as stated in the policy.

Long-Term Disability Paid Claims (BIM0038)

G000XXXX: ABC Inc
Period: 01/01/2004 to 07/06/2004
Run Date: 07/06/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Estimated Return to Work	Benefit Expiration Date	Gross Benefit Amount	Paid Dates
GLTD0XXXX	1	JONES/LENORD	123456789	06/18/1965	07/27/2002	01/23/2003	N/A	06/18/2030	$920.82	12/23/2003 - 06/23/2004
GLTD0XXXX	1	HOWARD/TOM	234567890	09/25/1961	02/05/2003	08/13/2003	N/A	09/25/2026	$2,010.68	12/13/2003 - 04/13/2004
GLTD0XXXX	1	SOVEY	345678900	03/08/1973	08/15/2002	02/17/2003	N/A	03/07/2038	$8,532.00	12/17/2003 - 06/17/2004
	1 Total								$11,463.50	
GLTD0XXXX	1A	PENNY/JOHN	456789000	07/13/1966	07/15/2003	02/06/2004	N/A	07/03/2029	$1,792.90	02/06/2004 - 07/06/2004
GLTD0XXXX	1A	LOW/MARSHAL	567891234	08/18/1951	07/24/2003	01/29/2004	N/A	08/18/2016	$21,988.92	01/29/2004 - 07/01/2004
	1A Total								$23,781.82	
GLTD0XXXX Total									$35,245.32	
	Grand Total								$35,245.32	
Grand Total									$35,245.32	

LONG-TERM DISABILITY PENDED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have filed a disability claim
- Benefit amounts (prior to any tax deductions, less offsets), if available
- Reasons pended:
  - Awaiting entire claim form means all parts of the three-part claim form have not been received.
  - Awaiting disability decision means the case is under review and a decision has not yet been made.

Uses:

- Provides a concise view of pended claims on a monthly basis.

Additional Information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Long-Term Disability Pended Claims (BIM0043)

G000XXXX: ABC Inc.
Period: 03/01/2003 to 07/10/2004
Run Date: 07/12/2004

Policy	Dept	CertName	CertNum	DOB	Date of Disability	Gross Benefit Amount	Reason Pended
GLTD0XXXX	1A	MALLOY/MARY	123456789	10/01/1960	05/01/2004	$50.00	AWAITING DISABILITY DECISION
GLTD0XXXX	1A	THOMAS/TIM	234567890	05/04/1957	05/01/2004	$25.00	AWAITING ENTIRE CLAIM FORM
	1A Total					$75.00	
GLTD0XXXX Total						$75.00	
	Grand Total					$75.00	
Grand Total						$75.00	

LONG-TERM DISABILITY TERMED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been terminated from receiving additional disability benefits
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Benefit termination dates
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Reasons terminated:
    - * Released – never returned to work
    - * Offsets exceeds benefit amount
    - * Claim incomplete or withdrawn
    - * Passed away
    - * Met age limit or ADEA benefit
    - * Returned to work
    - * Not totally disabled – own occupation
    - * Current earnings not received
    - * Ineligible or policy exclusion
    - * Did not exceed elimination period
    - * Transferred to Long-Term Disability
    - * Not totally disabled – any occupation
    - * Rehabilitation settlement
    - * Settlement
    - * Advanced benefit settlement
    - * Proof of disability not received
    - * Reached maximum benefit

Uses:

- Provides a comprehensive view of terminated claims.

Limitations:

- A claimant may appear on the authorized and terminated reports if the claimant was authorized and terminated in the same reporting period.

Additional information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Long-Term Disability Termed Claims (BIM0047)

G000XXXX: ABC Inc.
Period: 03/01/2003 to 07/10/2004
Run Date: 07/12/2004

Mutual of Omaha

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Benefit Term Date	Benefit Expire Date	Total Paid	Reason Terminated
GLTD0XXXX	1	WOOD/LIZ	123456789	07/10/1965	10/24/2002	05/22/2003	07/25/2003	07/10/2030	$3,379.53	NOT TOTALLY DISABLED - OWN OCC
	1 Total								$3,379.53	
GLTD0XXXX Total									$3,379.53	
	Grand Total								$3,379.53	
Grand Total									$3,379.53	

Long-Term Disability New-Active-Term Case Summary (BIM0051)

G000XXXX: ABC Inc.
Period: 03/01/2003 to 07/10/2004
Run Date: 07/12/2004

Policy	Year	Month	New Cases	Active Cases	Term Cases
GLTD0XXXX	2003	3	0	1	0
GLTD0XXXX	2003	4	2	5	0
GLTD0XXXX	2003	5	0	3	0
GLTD0XXXX	2003	6	2	5	0
GLTD0XXXX	2003	7	0	5	0
GLTD0XXXX	2003	8	1	7	1
GLTD0XXXX	2003	9	0	5	0
GLTD0XXXX	2003	10	0	5	0
GLTD0XXXX	2003	11	0	5	0
GLTD0XXXX	2003	12	0	3	0
GLTD0XXXX	2004	1	0	6	0
GLTD0XXXX	2004	2	0	5	0
GLTD0XXXX	2004	3	0	5	0
GLTD0XXXX	2004	4	0	5	0
GLTD0XXXX	2004	5	0	5	0
GLTD0XXXX	2004	6	1	6	0
GLTD0XXXX	2004	7	0	1	0

Long-Term Disability New-Active Cases (BIM0055)

G000XXXX: ABC Inc.
Period: 03/01/2003 to 07/10/2004
Run Date: 07/12/2004

Mutual of Omaha

Policy	Employee	Address	Address2	City	State	ZIP	SSN	DOB	Gender	LDW		
GLTD0XXXX	BOLEY/SYDNEY	3108 NEALWOOD	# 159	ORLANDO	IA	32806	123456789	12/06/1956	F	09/16/2002		
GLTD0XXXX	BIGGS/TOMMY	2607 STRATHFORD		KINGWOOD	IA	77345	234567890	10/02/1969	F	05/28/2002		
GLTD0XXXX	COSTON/BETTY	19807 DAWN		HUMBLE	IA	77346	345678900	11/06/1948	F	05/15/2002		
GLTD0XXXX	STRIKE/LYNN	14474 KYLE		CONROE	NE	77306	456789123	08/25/1957	F	08/28/2003		
GLTD0XXXX	TURNER/GEORGE	520 ATAS RD	LOT G27	HUMBLE	NE	77396	567891234	02/15/1950	M	08/08/2002		
GLTD0XXXX	WOOD/LIZ	3027 SHAN LN		HUMBLE	NE	77396	678912345	07/10/1965	F	10/24/2002		
GLTD0XXXX Count	6											
Grand Count	6											

LONG-TERM DISABILITY

Customer Report Guide

These claim reports are useful claims management tools for our group policyholders who are experiencing a high level of LTD claims activity, or with at least 1,000 employees insured under the group. These reports are to be used as a claims management reporting tool for our policyholders, and are not intended for use in the determination of establishing pricing levels or future expected claims levels. All reported claim amounts are paid claims only, and do not reflect Disabled Life Reserves or future claims liability, nor do any of these reports reflect Incurred But Not Reported reserves.

Please contact your Mutual of Omaha Group Sales Office for additional details.

"Paid Claims by Cause" – Current vs Prior Period (BIM0068-A)

This report identifies LTD claims by cause (accident, illness and maternity) and compares the claims results from one period to another.

Purpose:
This report allows the user to identify if there is a higher proportion of claims in certain general categories, and to identify year-to-year trends in claims patterns.

"Distribution of LTD Paid Claims by Cause" – Current vs Prior Period (BIM0068-B)

This report identifies the group's distribution of the number of LTD claims by cause, and compares the results from one period to another.

Purpose:
This report allows the user to identify the general categories under which LTD claims are being incurred under the group. The user is able to identify if there are emerging trends and to take corrective actions.

"Claim Incidence Rate by Cause" – Current vs Prior Period (BIM0068-C)

This report identifies the group's LTD claim incidence rates over different reporting periods. The claim incidence rate is the number of LTD claims incurred "per 1,000" employees.

Purpose:
This report allows the user to identify emerging trends in the incidence rate for accidents, maternity, or illness. The user is able to identify if there are emerging tends and to take corrective actions.

"Average Paid Claims by Cause" – Current vs Prior Period (BIM0068-D)

This report identifies the average paid claims to-date for each LTD claim incurred under the group over different reporting periods. Reported figures do not include Disabled Life Reserves.

Purpose:
This report allows the user to determine if there are shifts in the average cost of LTD claims, and to take corrective action if necessary.

"Average Claim Duration by Cause" – Current vs Prior Period (BIM0068-E)

This report identifies the average LTD claim duration across broad categories between different reporting periods. Average claim durations are measured from the date of disability to the date of claim termination.

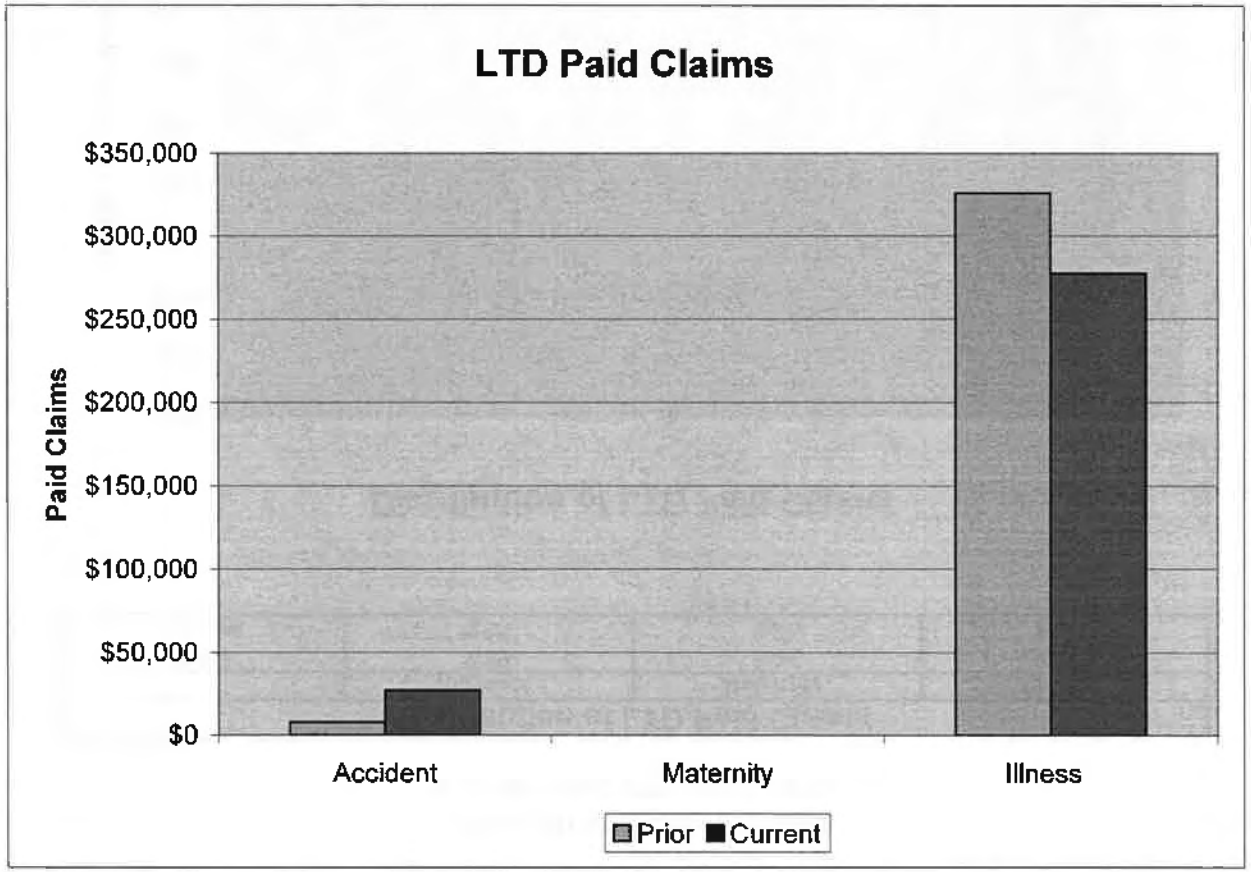
Purpose:
This report allows the user to determine if there are shifts in the average duration of LTD claims, and to take corrective action if necessary.

Long Term Disability
Paid Claims by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Long Term Disability Paid Claims				
	Accident	Maternity	Illness	Total
Prior	$7,611.15	$0.00	$325,752.18	$333,363.33
Current	$27,202.04	$0.00	$277,296.96	$304,499.00

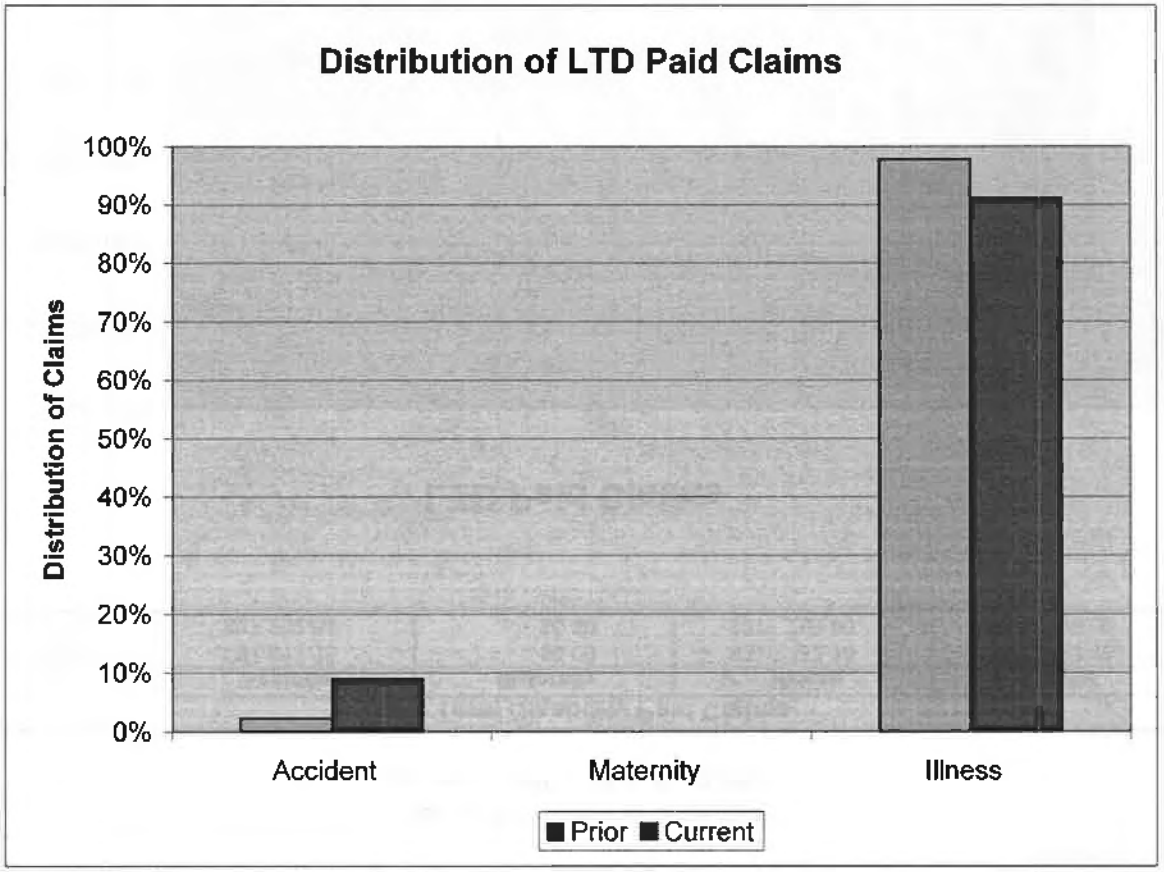


Long Term Disability
Distribution of Paid Claims by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Distribution of LTD Paid Claims			
	Accident	Maternity	Illness
Prior	2.3%	0.0%	97.7%
Current	8.9%	0.0%	91.1%

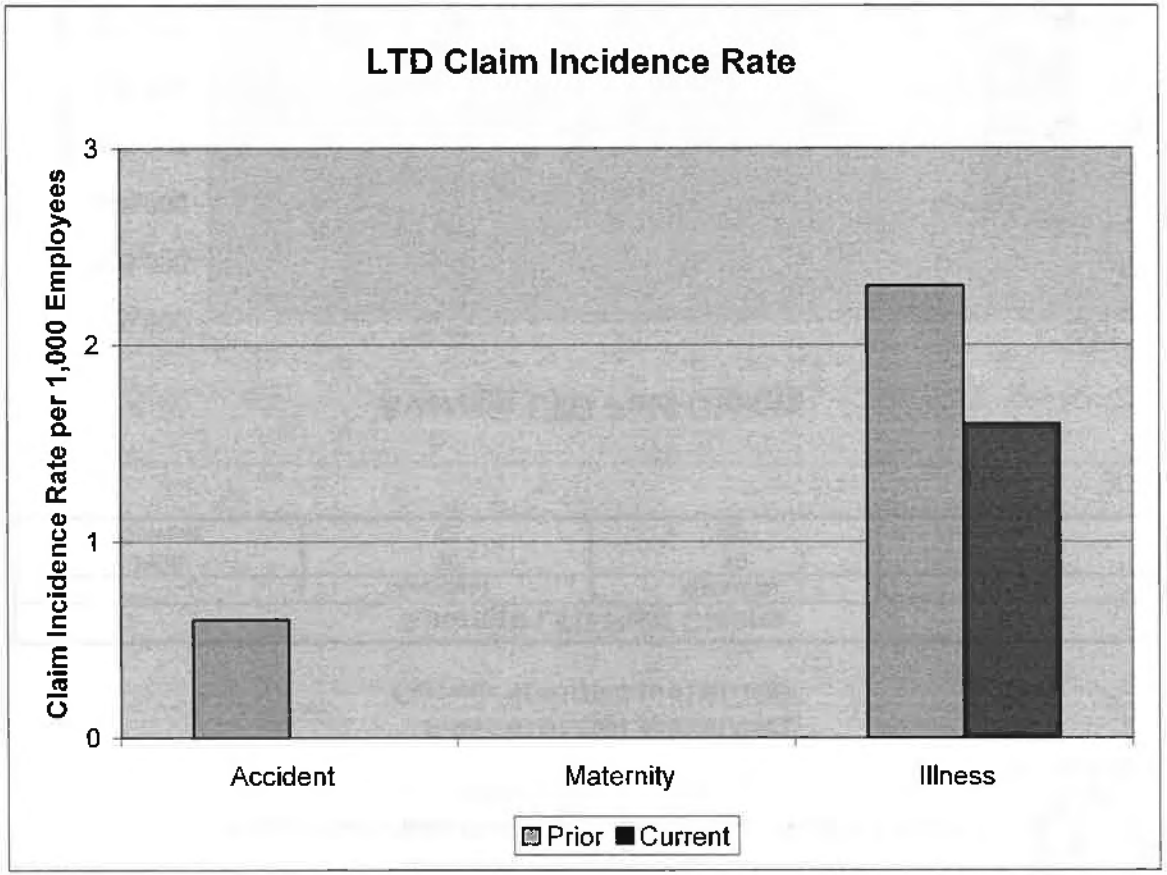


Long Term Disability
Claim Incidence Rate by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

LTD Claim Incidence Rate (per 1,000 covered employees)			
	Accident	Maternity	Illness
Prior	0.6	0.0	2.3
Current	0.0	0.0	1.6



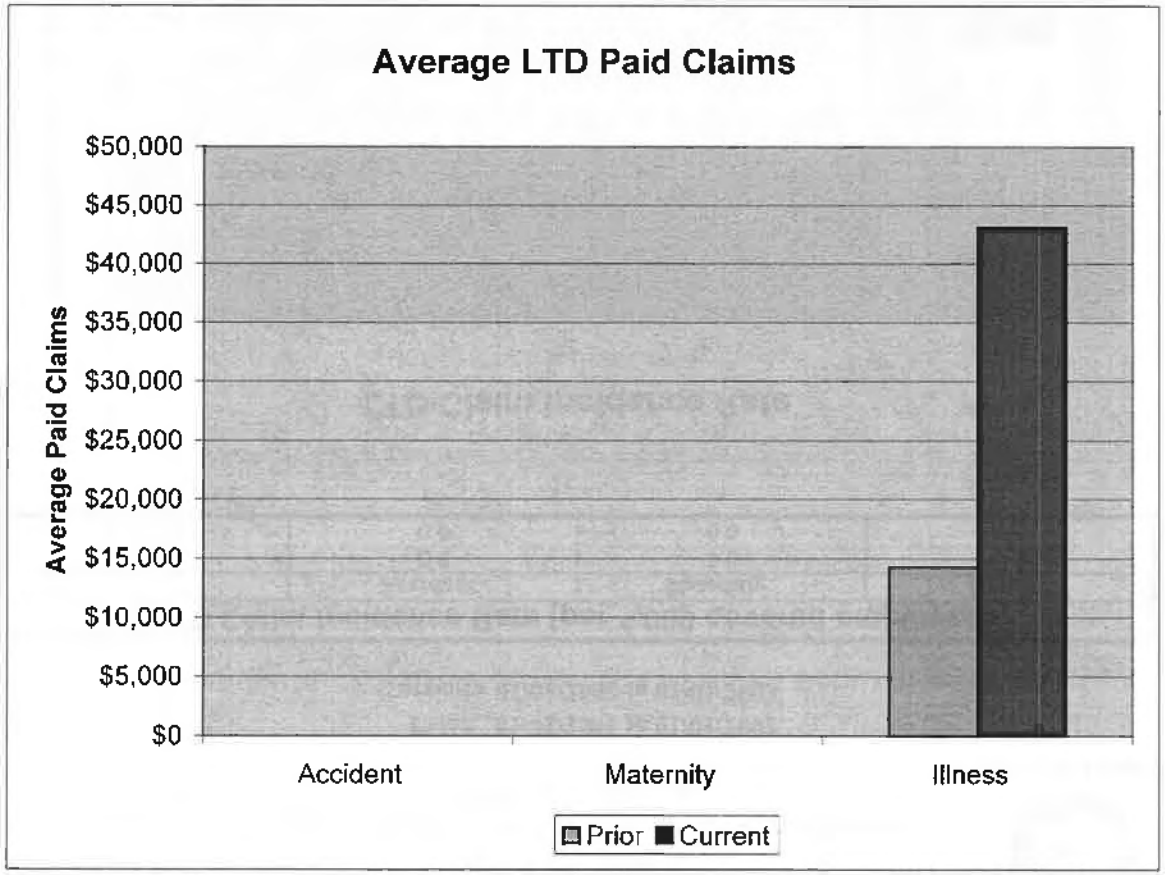
BIM0068-C

Long Term Disability
Average Paid Claim Dollars by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Average LTD Paid Claims			
	Accident	Maternity	Illness
Prior	$0	$0	$14,227
Current	$0	$0	$43,070



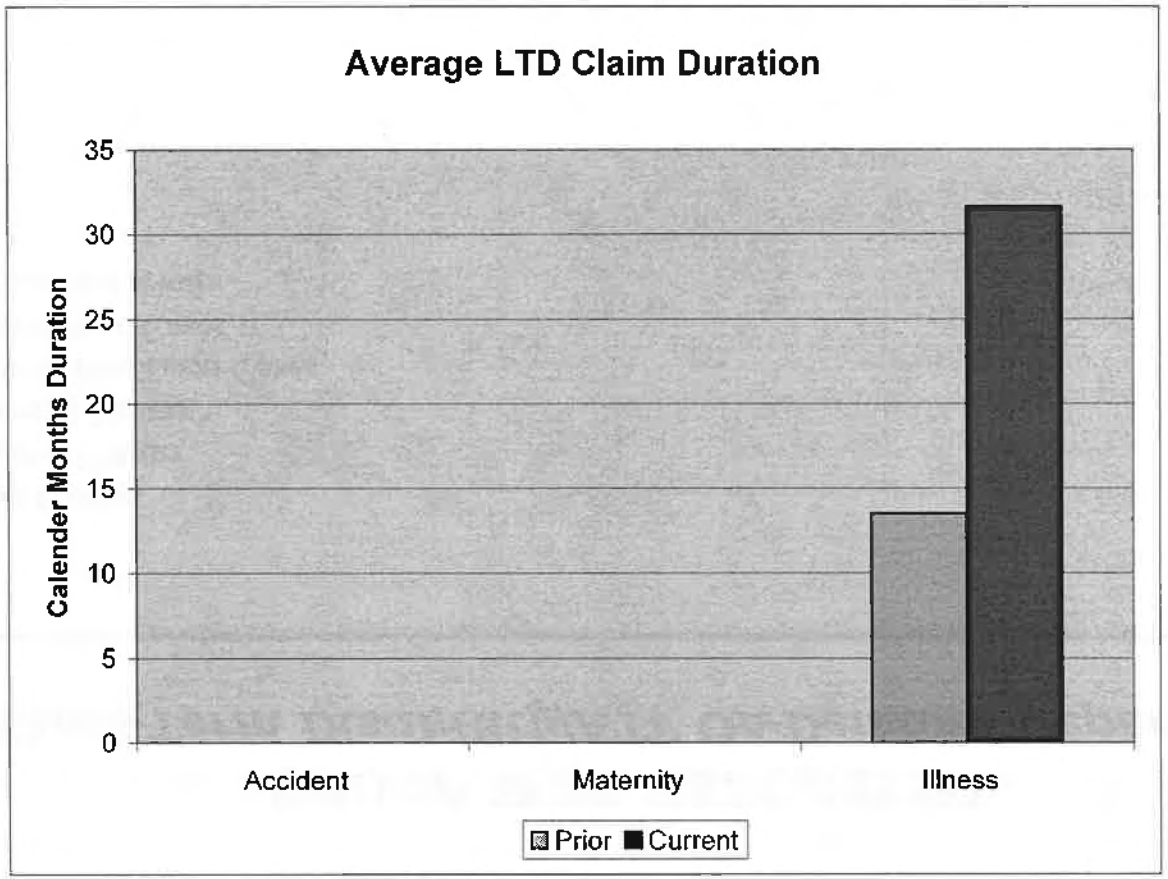
BIM0068-D

Long Term Disability
Average Claim Duration by Cause - Current Vs Prior Period
G000XXXX ABC Inc.

Mutual of Omaha

Prior: 01/01/2001 to 01/01/2002
Current: 01/01/2002 to 01/01/2003

Average LTD Claim Duration (months)			
	Accident	Maternity	Illness
Prior	0.0	0.0	13.5
Current	0.0	0.0	31.6



GROUP WEB REPORTING
Short-Term Disability/ATP On-Demand Reports

- **Paid Claims**
- **Pended Claims**
- **Termed Claims**
- **New/Active/Term Cases**
- **New/Active Cases**
- **Period to Period**

SHORT-TERM DISABILITY/ATP AUTHORIZED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been paid a disability benefit
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Estimated return to work dates (Physician's recommendation or the Mutual of Omaha Companies disability duration guideline, whichever is lesser)
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Authorized dates (range of time from which benefits were paid in the stated period)

Uses:

- Provides a comprehensive view of authorized claims.
- Allows Policyholder to verify accuracy and timeliness of benefit payments.
- Assists with salary continuation planning and/or payment.
- Identifies whether temporary help will need to be hired, based on estimated return-to-work date.

Limitations:

- The estimated return to work date may fluctuate based on the claimant's disability. If no date appears, then the claimant has either been terminated (see terminated report), an estimated return-to-work date has not been established or the disability may be so severe that the claimant is not expected to return to work.
- A claimant may appear on the paid and terminated reports if the claimant was paid and terminated in the same reporting period.
- If the estimated return-to-work date equals the benefit expiration date, then either the claimant is not expected to return to work or it is anticipated that the disability will run the maximum benefit duration, as stated in the policy.

Short-Term Disability/ATP Paid Claims (BIM0041)

G000XXXX: ABC Inc.
Period: 06/29/2004 to 07/29/2004
Run Date: 07/29/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Estimated Return to Work	Benefit Expiration Date	Authorized Dates
GUSIBXXXX	1A	ALAN/TERRY	123456789	03/08/1965	07/23/2004	07/30/2004	09/03/2004	01/28/2005	07/23/2004 - 08/06/2004
GUSIBXXXX	1A	CARR/DAWN	234567890	03/15/1971	07/14/2004	07/21/2004	09/11/2004	01/19/2005	07/14/2004 - 08/04/2004
GUSIBXXXX	1A	DAWSON/KARL	345678901	07/02/1963	06/14/2004	06/19/2004	10/13/2004	12/20/2004	06/14/2004 - 07/23/2004
GUSIBXXXX	1A	HARPER/BONNIE	456789012	10/08/1949	06/23/2004	06/30/2004	09/04/2004	12/29/2004	06/23/2004 - 08/04/2004
	1A Count		4						
GUSIBXXXX Count			4						
	Grand Count		4						
Grand Count			4						

SHORT-TERM DISABILITY/ATP PENDED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have filed a disability claim
- Reasons pended:
  - Awaiting entire claim form means all parts of the three-part claim form have not been received.
  - Awaiting disability decision means the case is under review and a decision has not yet been made.

Uses:

- Provides a concise view of pended claims on a monthly basis.

Additional Information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Short-Term Disability/ATP Pended Claims (BIM0046)

G000XXXX: ABC Inc.
Period: 07/12/2004 to 07/18/2004
Run Date: 07/19/2004

Mutual of Omaha

Policy	Dept	CertName	CertNum	DOB	Date of Disability	Reason Pended
GUSIBXXXX	1	SHRECK/CHAD	123456789	06/14/1963	07/12/2004	AWAITING DISABILITY DECISION
	1 Count		1			
GUSIBXXXX Count			1			
	Grand Count		1			
Grand Count			1			

SHORT-TERM DISABILITY/ATP TERMED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been terminated from receiving additional disability benefits
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Benefit termination dates
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Reasons terminated:
  - * Released – never returned to work
  - * Offsets exceeds benefit amount
  - * Claim incomplete or withdrawn
  - * Passed away
  - * Met age limit or ADEA benefit
  - * Returned to work
  - * Not totally disabled – own occupation
  - * Current earnings not received
  - * Ineligible or policy exclusion
  - * Did not exceed elimination period
  - * Transferred to Long-Term Disability
  - * Not totally disabled – any occupation
  - * Rehabilitation settlement
  - * Settlement
  - * Advanced benefit settlement
  - * Proof of disability not received
  - * Reached maximum benefit

Uses:

- Provides a comprehensive view of terminated claims.

Limitations:

- A claimant may appear on the authorized and terminated reports if the claimant was authorized and terminated in the same reporting period.

Additional information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Short-Term Disability/ATP Termed Claims (BIM0050)

G000XXXX: ABC Inc.
Period: 07/12/2004 to 07/29/2004
Run Date: 07/29/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Benefit Term Date	Benefit Expire Date	Reason Terminated
GUSIBXXXX	1	AVRIL/RALPH	123456789	12/13/1973	04/01/2004	04/08/2004	06/01/2004	08/26/2004	RETURNED TO WORK
GUSIBXXXX	1	STATER/TOM	234567890	03/20/1961	04/01/2004	04/08/2004	07/14/2004	07/14/2004	TRANSFERRED TO LONG-TERM DISABILITY
	1 Count		2						
GUSIBXXXX Count			2						
	Grand Count		2						
Grand Count			2						

Short-Term Disability/ATP New-Active-Term Case Summary (BIM0054)

G000XXXX: ABC Inc
Period: 01/01/2004 to 06/23/2004
Run Date: 06/23/2004

Policy	Year	Month	New Cases	Active Cases	Term Cases
GUSI0XXXX	2004	1	4	20	4
GUSI0XXXX	2004	2	1	11	8
GUSI0XXXX	2004	3	0	1	1
GUSIBXXXX	2004	1	2	6	0
GUSIBXXXX	2004	2	2	13	1
GUSIBXXXX	2004	3	1	13	4
GUSIBXXXX	2004	4	1	7	0
GUSIBXXXX	2004	5	1	5	1
GUSIBXXXX	2004	6	2	8	2

Short-Term Disability New-Active Cases (BIM0058)

G000XXXX: ABC Inc.
Period: 04/01/2004 to 07/22/2004
Run Date: 07/22/2004

Mutual of Omaha

Policy	Employee	Address	Address2	City	State	ZIP	SSN	DOB	Gender	LDW	ICD9	Diagnosis
GUSIBXXXX	ARNOLD/RALPH	4346 S CAMP DR.		LEWIS	NE	60632	123456789	12/13/1973	M	04/01/2004	07051	Ac VH C w/o coma
GUSIBXXXX	HERTMAN/FRAN	521 N WASHTENAW DR.		LEWIS	NE	60629	234567890	07/17/1963	M	05/06/2004	37240	Pterygium NOS
GUSIBXXXX	HOMER/CHUCK	PO BOX 13		HANZEL	NE	60429	345678901	12/08/1961	M	06/02/2004	37923	Vitreous hemorrhage
GUSIBXXXX	MALVIN/WALLY	15810 SHERWOOD ST		STANFORD	NE	46356	456789012	03/14/1955	M	04/15/2004	490	Bronchitis NOS
GUSIBXXXX	RIVERS/LONNY	1829 UNION AVE		MITCHELL	IA	60406	567890123	01/01/1960	M	04/09/2004	7999	Unkn cause morb/mort NEC
GUSIBXXXX	STATE/TRUDIE	126 N BISHOP ST		HALSEY	IA	60627	678901234	03/20/1961	M	04/01/2004	43822	Late eff CVD-nondom HEMI

SHORT-TERM DISABILITY/ADVICE TO PAY

Customer Report Guide

These claim reports are useful claims management tools for our group policyholders who are experiencing a high level of STD/ATP claims activity, or with at least 1,000 employees insured under the group. These reports are to be used as a claims management reporting tool for our policyholders, and are not intended for use in the determination of establishing pricing levels or future expected claims levels.

Please contact your Mutual of Omaha Group Sales Office for additional details.

"Claim Incidence Rate by Cause" – Current vs Prior Period (BIM0077-A)

This report identifies the group's STD/ATP claim incidence rates over different reporting periods. The claim incidence rate is the number of STD/ATP claims incurred "per 1,000" employees.

Purpose:
This report allows the user to identify emerging trends in the incidence rate for accidents, maternity, or illness. The user is able to identify if there are emerging tends and to take corrective actions.

"Average Claim Duration by Cause" – Current vs Prior Period (BIM0077-B)

This report identifies the average STD claim duration across broad categories between different reporting periods. Average claim durations are measured from the date of disability to the date of claim termination.

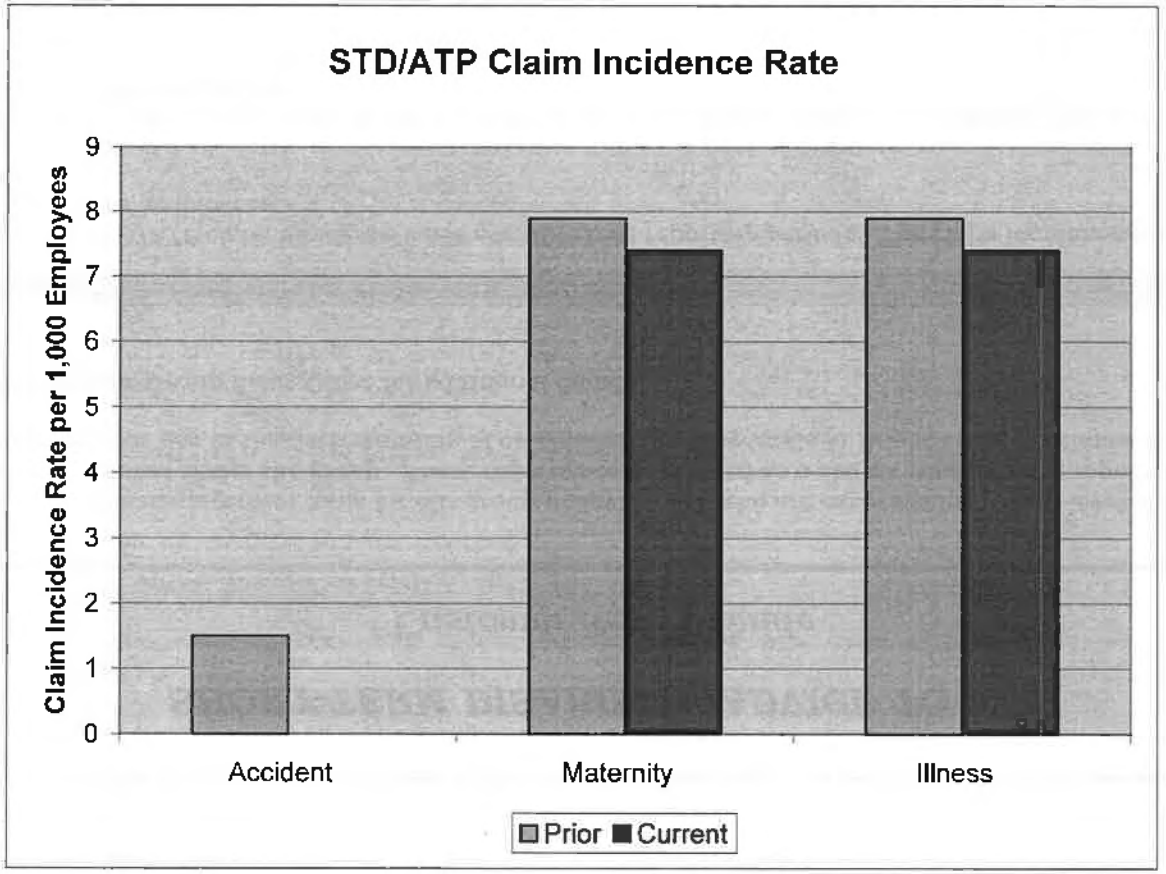
Purpose:
This report allows the user to determine if there are shifts in the average duration of STD/ATP claims, and to take corrective action if necessary.

Short Term Disability/Advice To Pay
Claim Incidence Rate by Cause - Current Vs Prior Period
G000XXXX: ABC Inc.

Mutual of Omaha

Prior: 01/01/2003 to 07/01/2003
Current: 01/01/2004 to 07/01/2004

STD/ATP Claim Incidence Rate (per 1,000 covered employees)			
	Accident	Maternity	Illness
Prior	1.5	7.9	7.9
Current	0.0	7.4	7.4

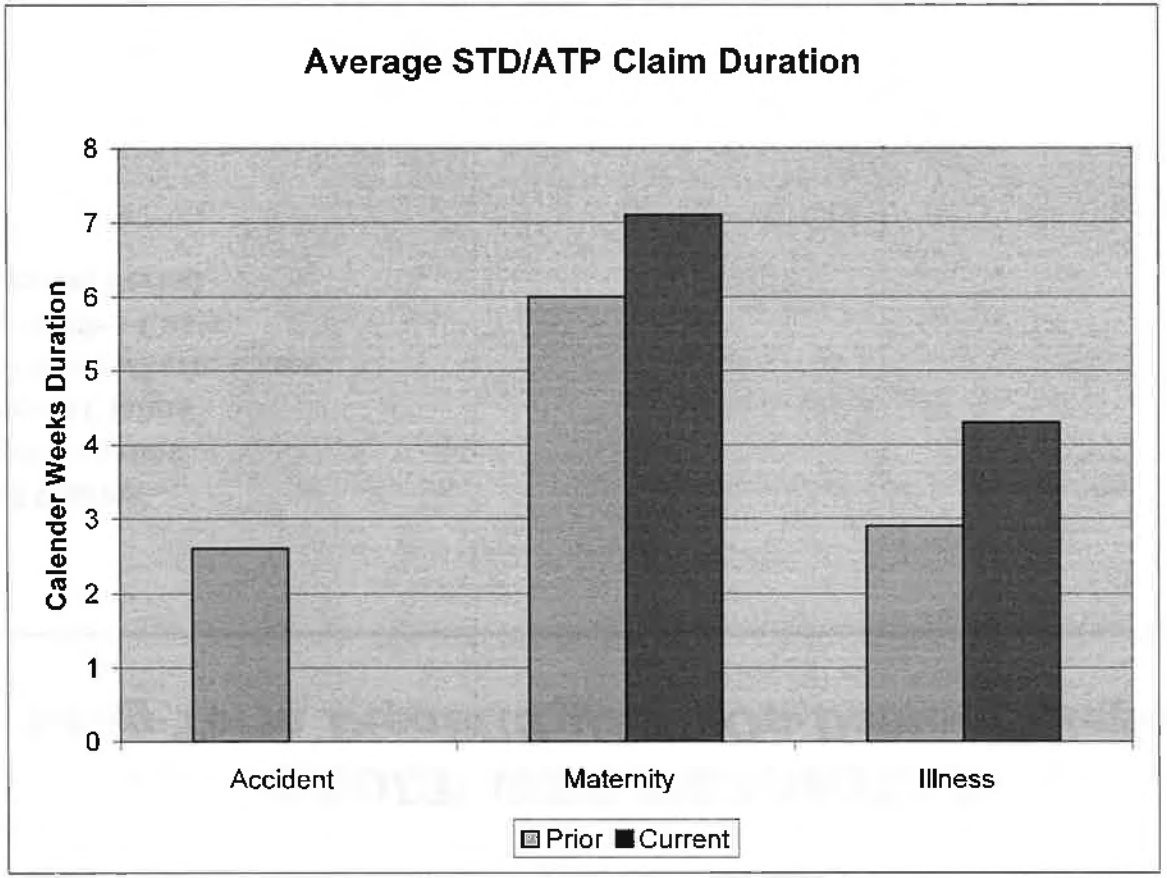


BIM0077-A

Short Term Disability/Advice To Pay
Average Claim Duration by Cause - Current Vs Prior Period
G000XXXX: ABC Inc.

Prior: 01/01/2003 to 07/01/2003
Current: 01/01/2004 to 07/01/2004

Average STD/ATP Claim Duration (weeks)			
	Accident	Maternity	Illness
Prior	2.6	6.0	2.9
Current	0.0	7.1	4.3



GROUP WEB REPORTING
Long-Term Disability/ATP On-Demand Reports

- Paid Claims
- Pended Claims
- Termed Claims
- New/Active/Term Cases
- New/Active Cases
- Period to Period

LONG-TERM DISABILITY/ATP AUTHORIZED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been paid a disability benefit
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Estimated return to work dates (Physician's recommendation or the Mutual of Omaha Companies disability duration guideline, whichever is lesser) or the date benefits have been approved to
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Authorized dates (range of time from which benefits were paid in the stated period)

Uses:

- Provides a comprehensive view of authorized claims.
- Allows Policyholder to verify accuracy and timeliness of benefit payments.
- Assists with salary continuation planning and/or payment.
- Identifies whether temporary help will need to be hired, based on estimated return-to-work date.

Limitations:

- The estimated return to work date may fluctuate based on the claimant's disability. If no date appears, then the claimant has either been terminated (see terminated report), an estimated return-to-work date has not been established or the disability may be so severe that the claimant is not expected to return to work.
- A claimant may appear on the paid and terminated reports if the claimant was paid and terminated in the same reporting period.
- If the estimated return-to-work date equals the benefit expiration date, then either the claimant is not expected to return to work or it is anticipated that the disability will run the maximum benefit duration, as stated in the policy.

Long-Term Disability/ATP Paid Claims (BIM0039)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/29/2004
Run Date: 07/29/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Estimated Return to Work	Benefit Expiration Date	Authorized Dates
GUSITXXXX	AEG1 IL02	DETTO/FRAN	123456789	12/20/1940	11/30/1995	05/28/1996	09/31/2004	01/01/2006	01/01/2004 - 07/01/2004
GUSITXXXX	AEG1 IL02	PATEL/RAVINE	234567890	04/20/1951	02/05/1999	08/13/1999	02/07/2005	05/01/2016	01/01/2004 - 07/01/2004
GUSITXXXX	AEG1 IL02	ROSS/JACK	345678901	05/09/1949	06/14/1998	12/21/1998	06/30/2005	06/01/2014	01/01/2004 - 07/01/2004
AEG1 IL02	**Count**		3						
GUSITXXXX	AEG1 IL08	DANIEL/FRED	456789012	04/30/1942	05/03/1994	10/30/1994	12/31/2004	01/01/2005	01/01/2004 - 07/01/2004
GUSITXXXX	AEG1 IL08	NASHVILLE/LYNDA	567890123	10/26/1941	06/05/1997	12/11/1997	05/31/2005	11/01/2007	01/01/2004 - 07/01/2004
AEG1 IL08	**Count**		2						
GUSITXXXX Count			5						
	Grand Count		5						
Grand Count			5						

LONG-TERM DISABILITY/ATP PENDED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have filed a disability claim
- Reasons pended:
  - Awaiting entire claim form means all parts of the three-part claim form have not been received.
  - Awaiting disability decision means the case is under review and a decision has not yet been made.

Uses:

- Provides a concise view of pended claims on a monthly basis.

Additional Information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Long-Term Disability/ATP Pended Claims (BIM0044)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/29/2004
Run Date: 07/29/2004

Mutual of Omaha

Policy	Dept	CertName	CertNum	DOB	Date of Disability	Reason Pended
GUSITXXXX	CGISS FL08	FARR/KYLE	123456789	01/23/1973	03/10/2004	AWAITING ENTIRE CLAIM FORM
CGISS FL08 Count			1			
GUSITXXXX	CGISS IL02	HENRY/JORDAN	234567890	09/19/1960	02/04/2004	AWAITING ENTIRE CLAIM FORM
GUSITXXXX	CGISS IL02	LEEK/DEBRA	345678901	10/26/1958	01/01/1901	AWAITING ENTIRE CLAIM FORM
CGISS IL02 Count			2			
GUSITXXXX	CGISS IL105	BRAHM/KURT	456789012	12/19/1958	01/01/1901	AWAITING ENTIRE CLAIM FORM
CGISS IL105 Count			1			
GUSITXXXX Count			4			
	Grand Count		4			
Grand Count			4			

LONG-TERM DISABILITY/ATP TERMED CLAIMS

Customer Report Guide

This report identifies the following for the stated period:

- Names, social security numbers and birth dates of those employees who have been terminated from receiving additional disability benefits
- Disability start dates (as confirmed by a Physician)
- Benefit start dates (benefits begin after the elimination period)
- Benefit termination dates
- Benefit expiration dates (maximum benefit duration, as stated in the policy)
- Reasons terminated:
    - * Released – never returned to work
    - * Offsets exceeds benefit amount
    - * Claim incomplete or withdrawn
    - * Passed away
    - * Met age limit or ADEA benefit
    - * Returned to work
    - * Not totally disabled – own occupation
    - * Current earnings not received
    - * Ineligible or policy exclusion
    - * Did not exceed elimination period
    - * Transferred to Long-Term Disability
    - * Not totally disabled – any occupation
    - * Rehabilitation settlement
    - * Settlement
    - * Advanced benefit settlement
    - * Proof of disability not received
    - * Reached maximum benefit

Uses:

- Provides a comprehensive view of terminated claims.

Limitations:

- A claimant may appear on the authorized and terminated reports if the claimant was authorized and terminated in the same reporting period.

Additional information:

- This report represents information that the disability customers request on a regular basis. If you have questions about this report, please contact your local Mutual of Omaha group representative.

Long-Term Disability/ATP Termed Claims (BIM0048)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/29/2004
Run Date: 07/29/2004

Policy	Dept	CertName	CertNum	DOB	Disability Start Date	Benefit Start Date	Benefit Term Date	Benefit Expire Date	Reason Terminated
GUSITXXXX	BAO	DESTIN/THERESA	123456789	06/10/1939	01/31/1992	07/30/1992	07/01/2004	07/01/2004	MET AGE LIMIT OR ADEA BENEFIT
	BAO Count		1						
GUSITXXXX	BCS PA06	HOLDER/ROBERT	234567890	07/29/1959	08/02/2003	02/09/2004	02/02/2004	08/01/2024	DID NOT EXCEED ELIMINATION PERIOD
	BCS PA06 Count		1						
GUSITXXXX	BCS TX14	WARRANT/ROBIN	345678901	02/25/1958	11/08/2001	05/07/2002	02/05/2004	03/01/2023	PASSED AWAY
	BCS TX14 Count		1						
GUSITXXXX	CE AZ49	GUIDRY/LYNDSEY	456789012	03/05/1940	01/07/1998	07/07/1998	06/27/2004	04/01/2005	PASSED AWAY
	CE AZ49 Count		1						
GUSITXXXX Count			4						
	Grand Count		4						
Grand Count			4						

Long-Term Disability/ATP New-Active-Term Case Summary (BIM0052)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/29/2004
Run Date: 07/29/2004

Policy	Year	Month	New Cases	Active Cases	Term Cases
GUSITXXXX	2004	1	12	734	33
GUSITXXXX	2004	2	6	710	22
GUSITXXXX	2004	3	6	719	24
GUSITXXXX	2004	4	5	708	20
GUSITXXXX	2004	5	5	697	14
GUSITXXXX	2004	6	5	718	18
GUSITXXXX	2004	7	3	171	15

Long-Term Disability/ATP New-Active Cases (BIM0056)

G000XXXX: ABC Inc.
Period: 01/01/2004 to 07/29/2004
Run Date: 07/29/2004

Mutual of Omaha

Policy	Employee	Address	Address2	City	State	ZIP	SSN	DOB	Gender	LDW	ICD9	Diagnosis
GUSITXXXX	ALEX/DONALD	220 TYSON DR		SYDNEY	NE	60095	345678901	04/14/1944	M	06/07/2003	78053	Hypersomn w sleep apnea
GUSITXXXX	ANDRETTI/TYRONE	475 NW 30TH ST		DAVID	IA	33314	234567890	07/25/1958	M	10/25/2003	1919	Brain CA NOS
GUSITXXXX	HAROLD/NITA	3100 WHITTING DR		LEWIS	NE	60050	123456789	12/28/1972	F	07/29/2003	7907	Bacteremia

LONG-TERM DISABILITY/ADVICE TO PAY

Customer Report Guide

These claim reports are useful claims management tools for our group policyholders who are experiencing a high level of LTD/ATP claims activity, or with at least 1,000 employees insured under the group. These reports are to be used as a claims management reporting tool for our policyholders, and are not intended for use in the determination of establishing pricing levels or future expected claims levels.

Please contact your Mutual of Omaha Group Sales Office for additional details.

"Claim Incidence Rate by Cause" – Current vs Prior Period (BIM0078-A)

This report identifies the group's LTD/ATP claim incidence rates over different reporting periods. The claim incidence rate is the number of LTD/ATP claims incurred "per 1,000" employees.

Purpose:
This report allows the user to identify emerging trends in the incidence rate for accidents, maternity, or illness. The user is able to identify if there are emerging tends and to take corrective actions.

"Average Claim Duration by Cause" – Current vs Prior Period (BIM0078-B)

This report identifies the average duration (in months) for each LTD/ATP claim incurred under the group over different reporting periods. Average claim durations are measured from the date of disability to the claim termination date.

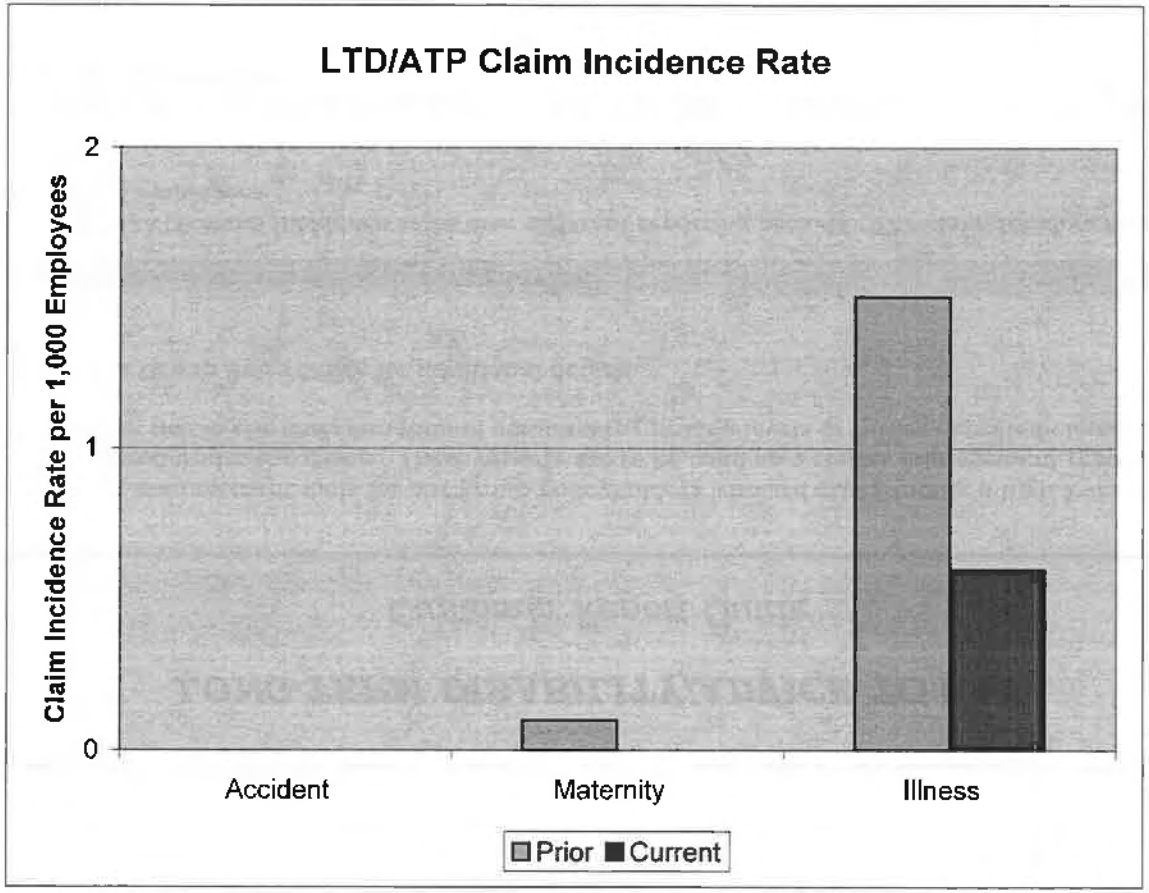
Purpose:
This report allows the user to determine if there are shifts in the average duration of LTD/ATP claims, and to take corrective action if necessary.

Long Term Disability/Advice To Pay
Claim Incidence Rate by Cause - Current Vs Prior Period
G000XXXX: ABC Inc.

Mutual of Omaha

Prior: 01/01/2003 to 07/01/2003
Current: 01/01/2004 to 07/01/2004

LTD/ATP Claim Incidence Rate (per 1,000 covered employees)			
	Accident	Maternity	Illness
Prior	0.0	0.1	1.5
Current	0.0	0.0	0.6



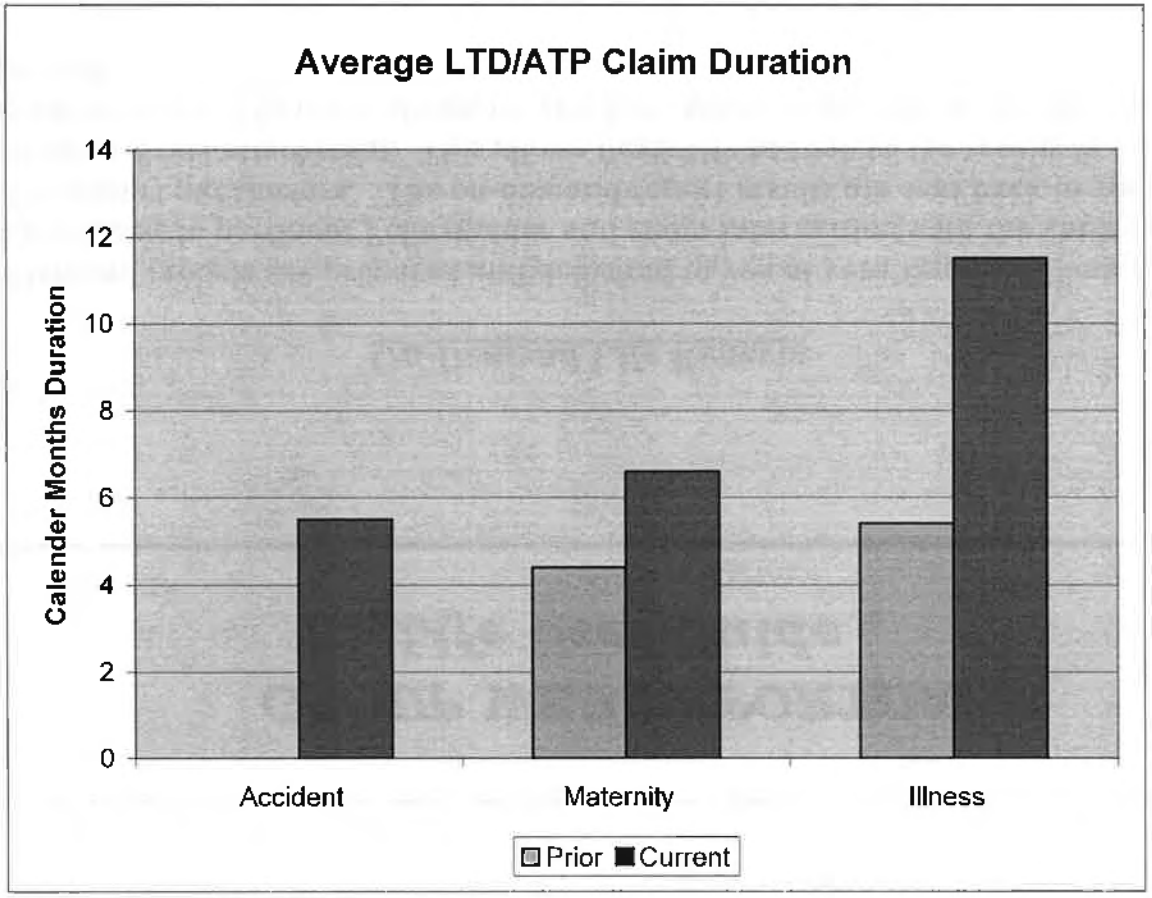
BIM0078-A

Long Term Disability/Advice To Pay
Average Claim Duration by Cause - Current Vs Prior Period
G000XXXX: ABC Inc.

Mutual of Omaha

Prior: 01/01/2003 to 07/01/2003
Current: 01/01/2004 to 07/01/2004

Average LTD/ATP Claim Duration (months)			
	Accident	Maternity	Illness
Prior	0.0	4.4	5.4
Current	5.5	6.6	11.5



BIM0078-B

GROUP WEB REPORTING
Life User Guide

On-Demand Life Reports

- **On-Demand reports are prepared and delivered to you at your request. These reports provide access to pertinent Policyholder and claim information with the ability to enter specific report parameters. The on-demand report results are sent back to your email inbox as an Excel attachment. This allows flexibility to analyze the results in a variety of different ways. The types of reports you have access to depend on the products purchased.**

GROUP WEB REPORTING
Life On-Demand Reports

Mutual of Oman

- **Life Paid Claims**
- **Waiver of Premium**
- **Extension of Life Insurance Coverage**
- **Pending Life Claims Report**

LIFE PAID CLAIMS REPORT

Customer Report Guide

This report shows all death and dismemberment claims for a particular policy that have been paid or adjusted during the time period specified at the time of request. The detail on this report is limited to claims with benefit types of Life, Supplemental Life, Accidental Death & Dismemberment and Paid Up.

Definitions

Life Policy – Policy number
Department – Department of the claimant
Claim Number – Claim number
Notice Date – This is the date the claim was received.
Proof Date – Identifies the date that death/disability was verified. If verification was not required, this date will be the same as the Notice Date.
Paid Date – This is the date that the claim was paid.
Birth Date – Date of birth of the claimant.
Last Name – Last name of the claimant.
First Name – First name of the claimant.
Benefit – Total amount paid for a particular benefit.

Life Paid Claims Reports (BIM0101)

G000XXXX: ABC Sample Company
Period: 01/01/2005 to 09/01/2005
Run Date: 09/21/2005

Life Policy	Department	Claim #	Notice Date	Proof Date	Paid Date	Incurred Date	Birth Date	Last Name	First Name	Benefit
G0000XXX		00011234	01/07/2005	01/07/2005	01/13/2005	06/30/2004	01/08/1932	Last Name Sample	First Name	$45,000.00
G0000XXX		00011235	04/01/2005	04/08/2005	04/15/2005	03/14/2005	12/19/1934	Last Name Sample	First Name	$22,000.00
G0000XXX		00011236	09/15/2004	02/02/2005	02/07/2005	09/09/2004	04/19/1948	Last Name Sample	First Name	$58,000.00
G0000XXX		00011237	10/22/2004	02/02/2005	02/03/2005	09/23/2004	09/01/1962	Last Name Sample	First Name	$100,000.00
G0000XXX		00011238	01/07/2005	01/07/2005	01/13/2005	12/01/2004	03/02/1933	Last Name Sample	First Name	$50,000.00
G0000XXX		00011239	01/17/2005	01/17/2005	01/25/2005	12/28/2004	09/12/1925	Last Name Sample	First Name	$35,000.00
G0000XXX		00011240	01/24/2005	01/24/2005	01/26/2005	01/05/2005	06/03/1943	Last Name Sample	First Name	$21,000.00
G0000XXX		00011241	01/31/2005	01/31/2005	02/02/2005	12/27/2004	04/21/1930	Last Name Sample	First Name	$28,000.00
G0000XXX		00011242	01/31/2005	01/31/2005	02/02/2005	01/08/2005	05/20/1922	Last Name Sample	First Name	$21,500.00
G0000XXX		00011243	02/03/2005	02/03/2005	02/03/2005	12/17/2004	06/21/1931	Last Name Sample	First Name	$250,000.00
G0000XXX		00011244	02/14/2005	02/14/2005	02/21/2005	12/30/2004	05/13/1932	Last Name Sample	First Name	$50,000.00
G0000XXX		00011245	03/01/2005	03/01/2005	03/07/2005	01/14/2005	12/28/1942	Last Name Sample	First Name	$50,000.00
G0000XXX		00011246	03/01/2005	03/01/2005	03/07/2005	02/08/2005	08/12/1923	Last Name Sample	First Name	$20,500.00
G0000XXX		00011247	03/04/2005	03/04/2005	03/09/2005	02/13/2005	11/30/1916	Last Name Sample	First Name	$20,500.00
G0000XXX		00011248	03/08/2005	03/08/2005	03/11/2005	02/04/2005	01/25/1934	Last Name Sample	First Name	$50,000.00

WAIVER OF PREMIUM REPORT

Customer Report Guide

This report shows all current claims for a particular policy for which the premium has been waived due to disability of the claimant.

Definitions

Life Policy – Policy number
Claim No. – Claim number
Dept. Code – Department of the claimant.
Last Name – Last name of the claimant.
First Name – First name of the claimant.
MI – Middle Initial of the claimant.
DOB – Date of birth of the claimant.
Incurred Date – Identifies the date that the disability occurred.
Eff. Date of W.P. – Identifies the date the initial waiver activity occurred.
Face Amt. – Identifies the face amount of a waiver or extension of premium benefit.

Waiver of Premium Report (BIM0102)

G000XXXX: ABC Sample Company
As of: 09/22/2005

Policy	Claim No.	Dept. Code	Last Name	First Name	MI	DOB	Incurred Date	Eff. Date of W.P.	Face Amt.
G000XXXX	00001134		Sample Last	Sample First	A	05/11/1930	05/16/1976	01/06/1977	$20,500.00
G000XXXX	00001135		Sample Last	Sample First	B	07/15/1919	08/09/1977	03/01/1978	$28,000.00
G000XXXX	00001136		Sample Last	Sample First	C	03/04/1916	09/20/1977	04/01/1978	$41,000.00
G000XXXX	00001137		Sample Last	Sample First	A	08/03/1930	08/31/1979	04/01/1980	$50,000.00
G000XXXX	00001138		Sample Last	Sample First	B	02/23/1920	05/13/1980	01/01/1981	$25,500.00
G000XXXX	00001139		Sample Last	Sample First	C	10/30/1923	12/20/1981	07/01/1982	$37,000.00
G000XXXX	00001140		Sample Last	Sample First	A	07/23/1921	07/01/1983	02/01/1984	$50,000.00
G000XXXX	00001141		Sample Last	Sample First	B	07/11/1953	05/07/1987	11/07/1987	$148,000.00
G000XXXX	00001142		Sample Last	Sample First	C	12/19/1961	05/21/1990	11/17/1990	$21,000.00
G000XXXX	00001143		Sample Last	Sample First	A	11/23/1943	08/03/1990	02/02/1991	$143,000.00
G000XXXX	00001144		Sample Last	Sample First		04/28/1960	09/08/1994	04/01/1995	$26,000.00

EXTENSION OF LIFE INSURANCE COVERAGE

Customer Report Guide

This report shows all current claimants for a particular policy that are under an extension of coverage of their life insurance policy.

Definitions

Life Policy – Policy number
Last Name – Last name of the claimant.
First Name – First name of the claimant.
MI – Middle Initial of the claimant.
Face Amt. – Identifies the face amount of a waiver or extension of premium benefit.
Apprvl Dt. – The date that the extension of coverage was approved.
Claim No. – Claim number
Inr. Date – Identifies the date that claim was incurred.
DOB – Date of birth of the claimant.

Extension of Life Insurance Coverage (BIM0103)

G000XXXX: ABC Sample Company
As of: 09/22/2005

Poliy	Last Name	First Name	M.I.	Face Amt.	Apprvl Dt.	Claim No.	Incr. Date	DOB
G000XXXX	Sample Last Name	Sample First	A	$54,000.00	06/16/2003	10051234	10/31/2002	08/12/1952
G000XXXX	Sample Last Name	Sample First	A	$36,000.00	02/01/2002	10051234	11/01/2000	09/02/1957
G000XXXX	Sample Last Name	Sample First	A	$24,000.00	05/24/2003	10051234	03/14/2003	10/22/1948
G000XXXX	Sample Last Name	Sample First	A	$282,000.00	04/17/2005	10051234	10/15/2004	10/07/1954
G000XXXX	Sample Last Name	Sample First	A	$53,000.00	07/01/2004	10051234	12/21/2004	10/06/1946
G000XXXX	Sample Last Name	Sample First	A	$100,000.00	01/18/2002	10051234	04/19/2001	07/15/1948
G000XXXX	Sample Last Name	Sample First	A	$44,000.00	08/11/2003	10051234	04/25/2003	07/20/1949
G000XXXX	Sample Last Name	Sample First	A	$184,000.00	08/01/2004	10051234	10/13/2003	06/14/1956
G000XXXX	Sample Last Name	Sample First	A	$44,000.00	09/01/2003	10051234	02/10/2003	11/28/1960
G000XXXX	Sample Last Name	Sample First	A	$43,000.00	09/01/2002	10051234	01/02/2002	08/12/1942
G000XXXX	Sample Last Name	Sample First	A	$236,000.00	10/16/2003	10051234	04/18/2003	01/19/1949

PENDING LIFE CLAIMS REPORT

Customer Report Guide

This report shows all current claims for a particular policy for which are in a pended status.

Definitions

Policy – Policy number
Dept. – Department of the claimant.
Claim No. – Claim number
Notice – Identifies the date the claim was received.
Incrd. Dte – Identifes the date that the death, disability, or dismemberment occurred.
DOB – Date of birth of the claimant.
Last Name – Last name of the claimant.
First Name – First name of the claimant.
Benefit – Identifies the total amount considered/paid for a benefit.

Pending Life Claims Report (BIM0104)

G000XXXX: ABC Sample Company
As of: 09/21/2005

Policy	Dept.	Claim No.	Notice	Incrd. Dte	DOB	Last Name	First Name	Benefit
G000XXXX		000001234	05/20/2005	03/28/2005	11/12/1945	Sample Last Name	First Name	$25,000.00
G000XXXX		000001235	09/19/2005	07/22/2005	06/20/1984	Sample Last Name	First Name	$20,000.00
G000XXXX		000001236	05/20/2005	03/28/2005	11/12/1945	Sample Last Name	First Name	$25,000.00

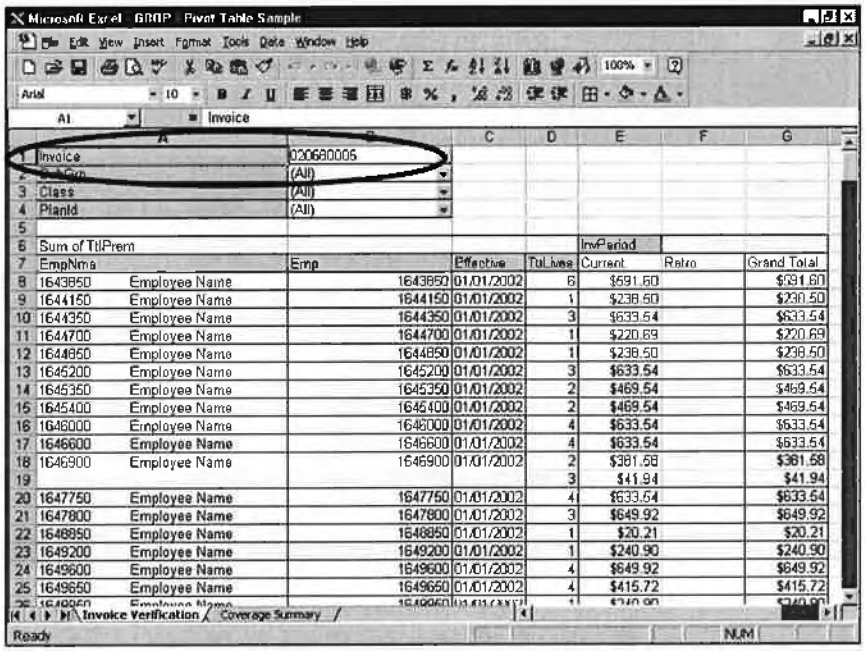
Pivot Table Training

Background: Some Mutual of Omaha reporting outputs are delivered in a Microsoft Excel workbook which contain one or more pivot tables. A Pivot Table is an interactive table that quickly summarizes, or cross-tabulates, large amounts of data. A user can rotate rows and columns to see different summaries of the source data, filter the data by displaying different pages or display the details for areas of interest.

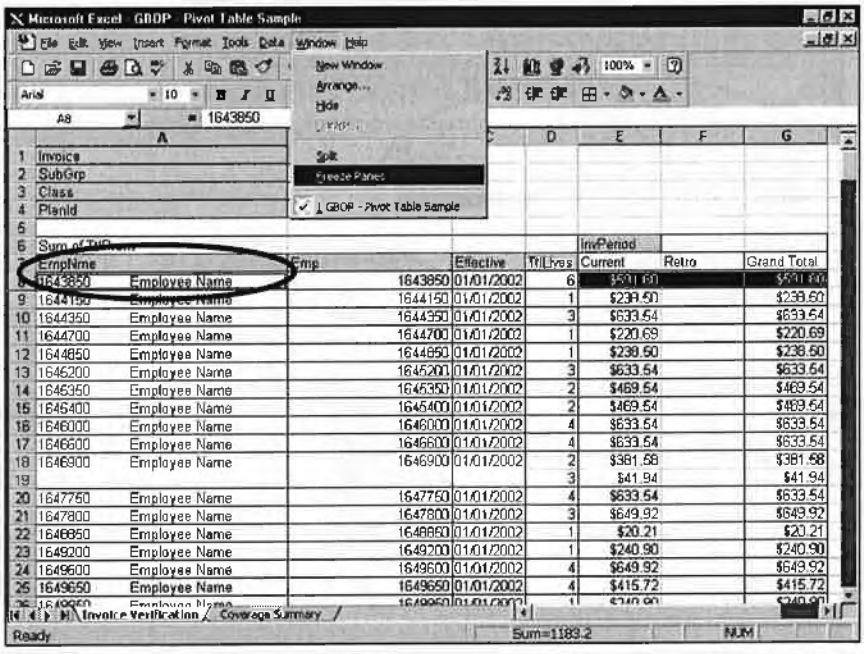
Purpose: The purpose of this training document is to provide a pivot table overview. The Invoice Verification Summary (BIM0018) will be used to illustrate the techniques. More detailed pivot table information is available in the Microsoft Excel documentation.

Working with Pivot Tables

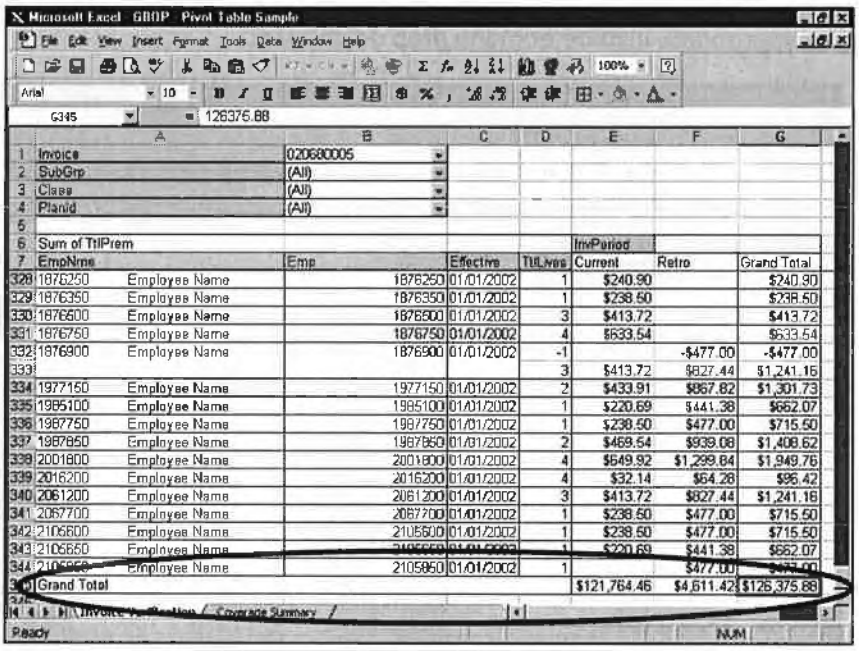
1. Verify that the Invoice number on the Pivot Table matches the invoice number on the premium bill. There may be more than one invoice attached to the Pivot Table. Select the appropriate invoice from the drop down menu.



2. To make the table easier to read, the column titles can be frozen. Click in the first cell under the column title. Select **Window...Freeze Panes**. The column titles will now remain while scrolling through the information.

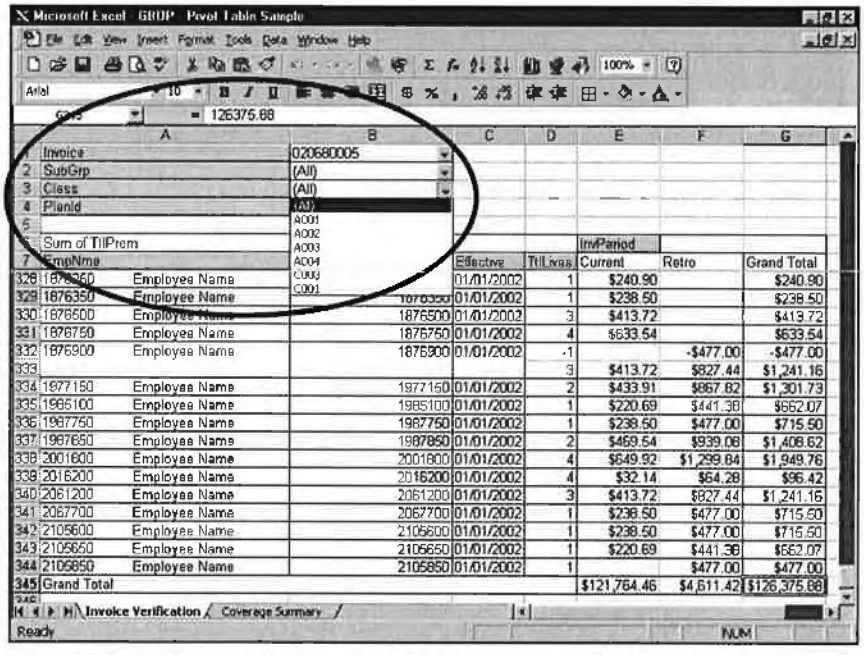


3. Press the **Control** and **End** keys simultaneously, to display the end of the sheet – where the Grand Totals are shown. These totals will match the grand totals on the premium bill.



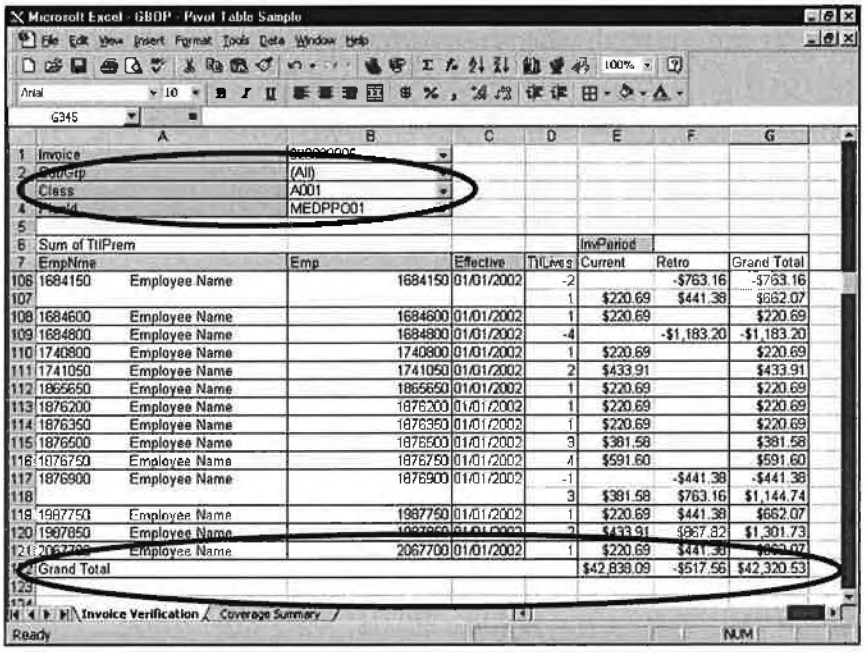
	A	B	C	D	E	F	G
1	Invoice	020680005					
2	SubGrp	(All)					
3	Class	(All)					
4	PlanId	(All)					
5							
6	Sum of TtlPrem				InvPeriod		
7	EmpNme	Emp	Effective	TtlLives	Current	Retro	Grand Total
328	1876250 Employee Name	1876250	01/01/2002	1	$240.90		$240.90
329	1876350 Employee Name	1876350	01/01/2002	1	$238.50		$238.50
330	1876500 Employee Name	1876500	01/01/2002	3	$413.72		$413.72
331	1876750 Employee Name	1876750	01/01/2002	4	$533.54		$533.54
332	1876900 Employee Name	1876900	01/01/2002	-1		-$477.00	-$477.00
333				3	$413.72	$827.44	$1,241.16
334	1977150 Employee Name	1977150	01/01/2002	2	$433.91	$867.82	$1,301.73
335	1985100 Employee Name	1985100	01/01/2002	1	$220.69	$441.38	$662.07
336	1987750 Employee Name	1987750	01/01/2002	1	$238.50	$477.00	$715.50
337	1987850 Employee Name	1987850	01/01/2002	2	$469.54	$939.08	$1,408.62
338	2001800 Employee Name	2001800	01/01/2002	4	$649.92	$1,299.84	$1,949.76
339	2016200 Employee Name	2016200	01/01/2002	4	$32.14	$64.28	$96.42
340	2061200 Employee Name	2061200	01/01/2002	3	$413.72	$827.44	$1,241.16
341	2067700 Employee Name	2067700	01/01/2002	1	$238.50	$477.00	$715.50
342	2105600 Employee Name	2105600	01/01/2002	1	$238.50	$477.00	$715.50
343	2105650 Employee Name	2105650	01/01/2002	1	$220.69	$441.38	$662.07
344	2105850 Employee Name	2105850	01/01/2002	1		$477.00	$477.00
345	Grand Total				$121,764.46	$4,611.42	$126,375.88

4. The information on the Invoice Verification sheet can be filtered to show subscribers under a particular subgroup, class, plan – or any combination of all three. To filter the information, make the appropriate selections from the drop down boxes in the upper left-hand corner of the table.



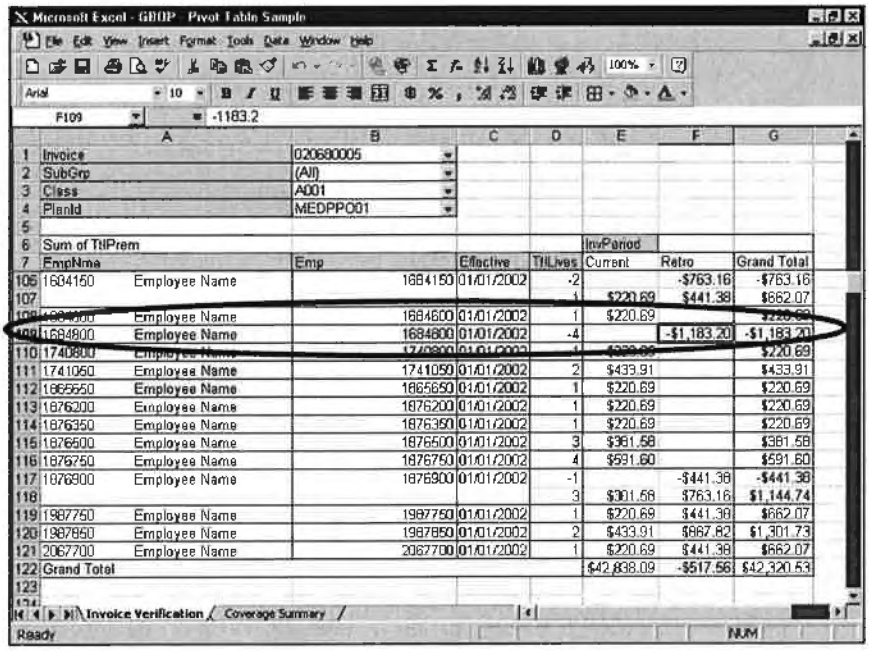
	A	B	C	D	E	F	G
1	Invoice	020680005					
2	SubGrp	(All)					
3	Class	(All)					
4	PlanId	(All)					
5		A001					
6	Sum of TtlPrem	A002			InvPeriod		
7	EmpNme	A003	Effective	TtlLives	Current	Retro	Grand Total
328	1876250 Employee Name	A004	01/01/2002	1	$240.90		$240.90
329	1876350 Employee Name	C003	01/01/2002	1	$238.50		$238.50
330	1876500 Employee Name	C001	01/01/2002	3	$413.72		$413.72
331	1876750 Employee Name	1876750	01/01/2002	4	$533.54		$533.54
332	1876900 Employee Name	1876900	01/01/2002	-1		-$477.00	-$477.00
333				3	$413.72	$827.44	$1,241.16
334	1977150 Employee Name	1977150	01/01/2002	2	$433.91	$867.82	$1,301.73
335	1985100 Employee Name	1985100	01/01/2002	1	$220.69	$441.38	$662.07
336	1987750 Employee Name	1987750	01/01/2002	1	$238.50	$477.00	$715.50
337	1987850 Employee Name	1987850	01/01/2002	2	$469.54	$939.08	$1,408.62
338	2001800 Employee Name	2001800	01/01/2002	4	$649.92	$1,299.84	$1,949.76
339	2016200 Employee Name	2016200	01/01/2002	4	$32.14	$64.28	$96.42
340	2061200 Employee Name	2061200	01/01/2002	3	$413.72	$827.44	$1,241.16
341	2067700 Employee Name	2067700	01/01/2002	1	$238.50	$477.00	$715.50
342	2105600 Employee Name	2105600	01/01/2002	1	$238.50	$477.00	$715.50
343	2105650 Employee Name	2105650	01/01/2002	1	$220.69	$441.38	$662.07
344	2105850 Employee Name	2105850	01/01/2002	1		$477.00	$477.00
345	Grand Total				$121,764.46	$4,611.42	$126,375.88

5. Below is an example of the filter function, asking for subscribers in Class A001, Plan MEDPPO01. The Grand Total line will match the line on the premium bill for Class A001, Plan MEDPPO01.



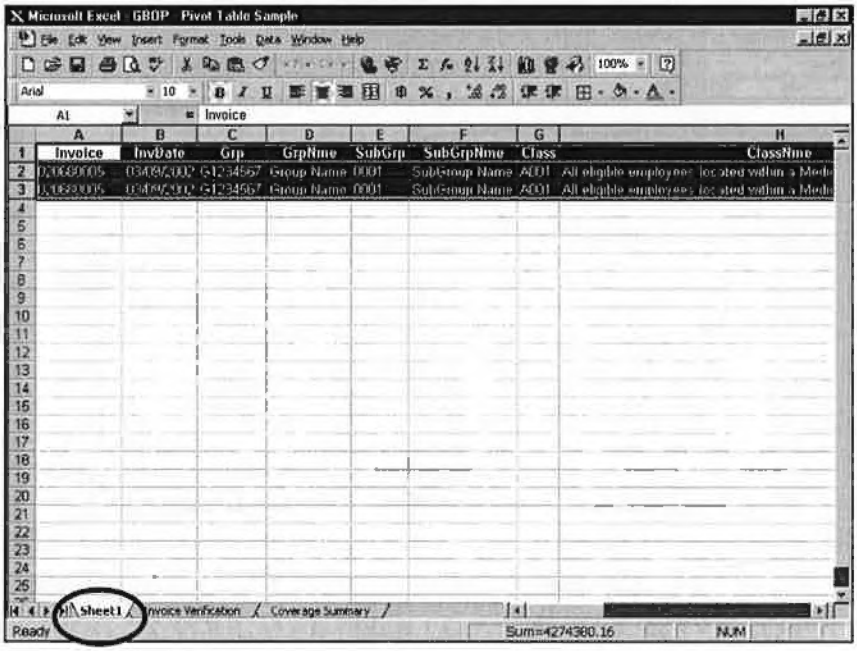
1	Invoice		[illegible]						
2	SubGrp		(All)						
3	Class		A001						
4	PlanId		MEDPPO01						
5									
6	Sum of TtlPrem						InvPeriod		
7	EmpNme		Emp	Effective	TtlLives	Current	Retro	Grand Total	
106	1684150	Employee Name	1684150	01/01/2002	-2		-$763.16	-$763.16	
107					1	$220.69	$441.38	$662.07	
108	1684600	Employee Name	1684600	01/01/2002	1	$220.69		$220.69	
109	1684800	Employee Name	1684800	01/01/2002	-4		-$1,183.20	-$1,183.20	
110	1740800	Employee Name	1740800	01/01/2002	1	$220.69		$220.69	
111	1741050	Employee Name	1741050	01/01/2002	2	$433.91		$433.91	
112	1865650	Employee Name	1865650	01/01/2002	1	$220.69		$220.69	
113	1876200	Employee Name	1876200	01/01/2002	1	$220.69		$220.69	
114	1876350	Employee Name	1876350	01/01/2002	1	$220.69		$220.69	
115	1876500	Employee Name	1876500	01/01/2002	3	$381.58		$381.58	
116	1876750	Employee Name	1876750	01/01/2002	4	$591.60		$591.60	
117	1876900	Employee Name	1876900	01/01/2002	-1		-$441.38	-$441.38	
118					3	$381.58	$763.16	$1,144.74	
119	1987750	Employee Name	1987750	01/01/2002	1	$220.69	$441.38	$662.07	
120	1987850	Employee Name	[illegible]	[illegible]	2	$433.91	$867.82	$1,301.73	
121	2067700	Employee Name	2067700	01/01/2002	1	$220.69	$441.38	$662.07	
122	Grand Total					$42,838.09	-$517.56	$42,320.53	

6. To view information for a particular subscriber, locate the subscriber on the table.



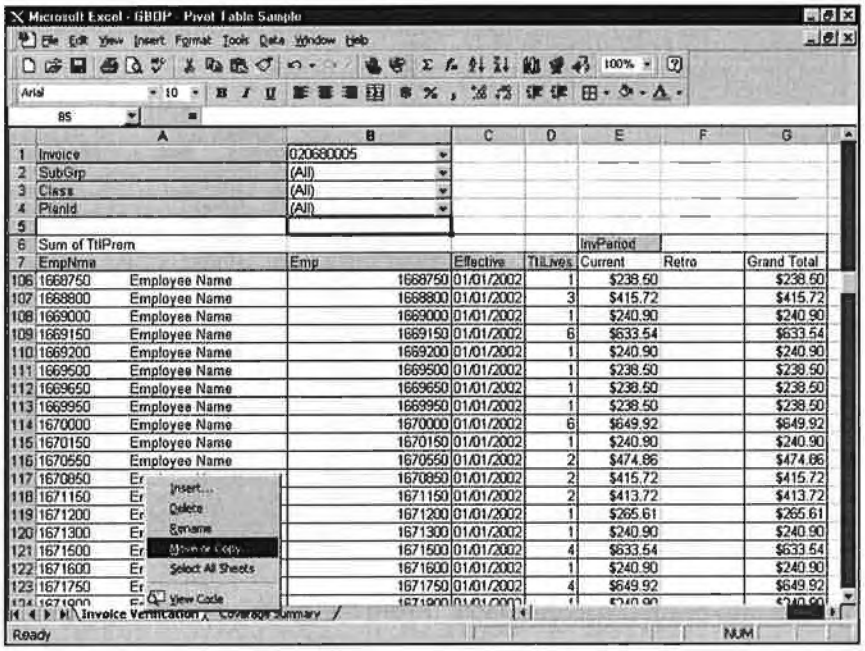
1	Invoice		020680005						
2	SubGrp		(All)						
3	Class		A001						
4	PlanId		MEDPPO01						
5									
6	Sum of TtlPrem						InvPeriod		
7	EmpNme		Emp	Effective	TtlLives	Current	Retro	Grand Total	
106	1684150	Employee Name	1684150	01/01/2002	-2		-$763.16	-$763.16	
107					1	$220.69	$441.38	$662.07	
108	1684600	Employee Name	1684600	01/01/2002	1	$220.69		$220.69	
109	1684800	Employee Name	1684800	01/01/2002	-4		-$1,183.20	-$1,183.20	
110	1740800	Employee Name	[illegible]	[illegible]	1	$220.69		$220.69	
111	1741050	Employee Name	1741050	01/01/2002	2	$433.91		$433.91	
112	1865650	Employee Name	1865650	01/01/2002	1	$220.69		$220.69	
113	1876200	Employee Name	1876200	01/01/2002	1	$220.69		$220.69	
114	1876350	Employee Name	1876350	01/01/2002	1	$220.69		$220.69	
115	1876500	Employee Name	1876500	01/01/2002	3	$381.58		$381.58	
116	1876750	Employee Name	1876750	01/01/2002	4	$591.60		$591.60	
117	1876900	Employee Name	1876900	01/01/2002	-1		-$441.38	-$441.38	
118					3	$381.58	$763.16	$1,144.74	
119	1987750	Employee Name	1987750	01/01/2002	1	$220.69	$441.38	$662.07	
120	1987850	Employee Name	1987850	01/01/2002	2	$433.91	$867.82	$1,301.73	
121	2067700	Employee Name	2067700	01/01/2002	1	$220.69	$441.38	$662.07	
122	Grand Total					$42,838.09	-$517.56	$42,320.53	

7. Double click on one of the dollar amounts. The detail for that subscriber is now showing. Note that Excel has created another worksheet to display this information. After viewing the subscriber information, the extra sheet can be deleted by right clicking on the sheet name and selecting **Delete**.

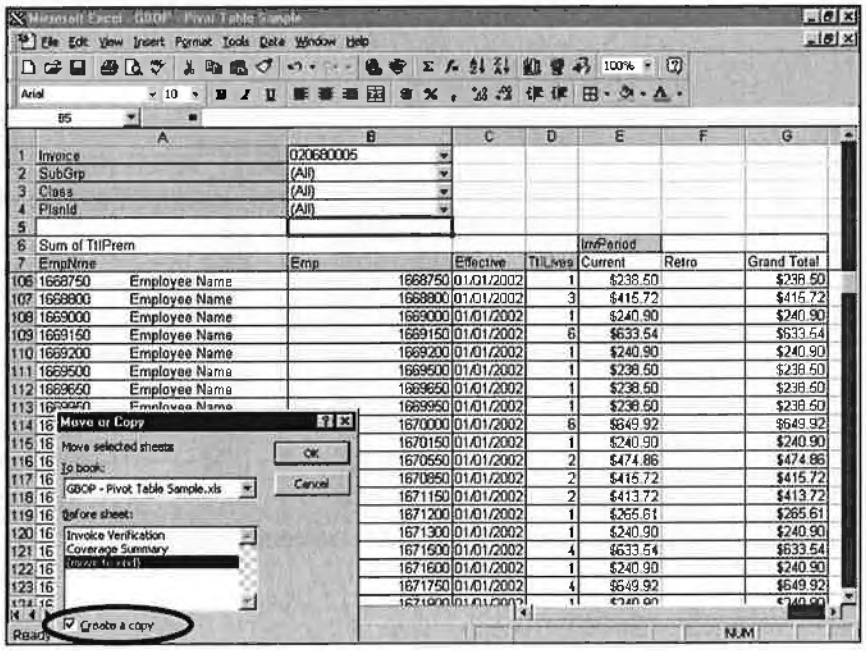


Creating Pivot Table Reports

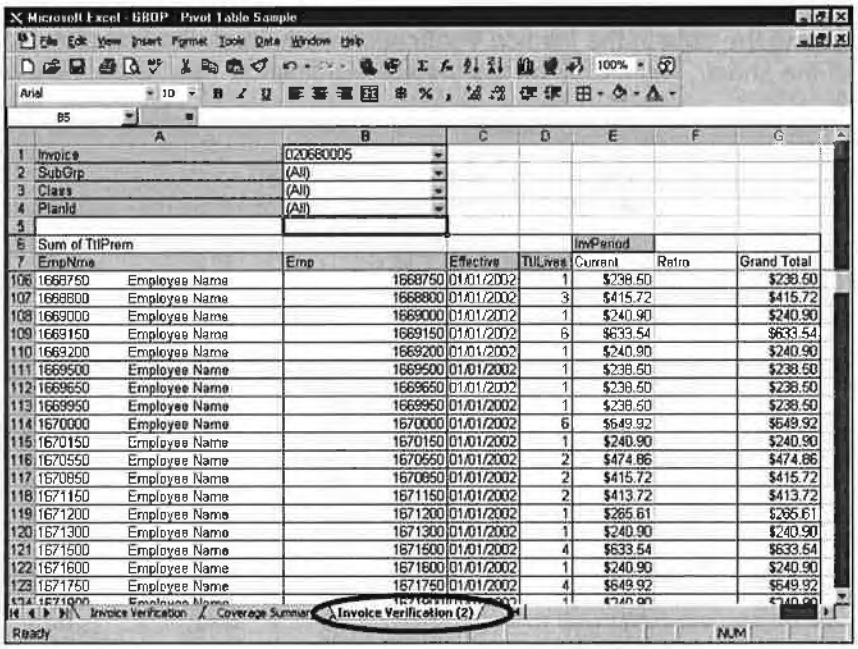
1. With Pivot Tables, a user also has the capability of creating their own report. To avoid losing the data in the Invoice Verification worksheet, the first step is to make a copy of the sheet. Right click on the Invoice Verification Tab. Select **Move or Copy**.



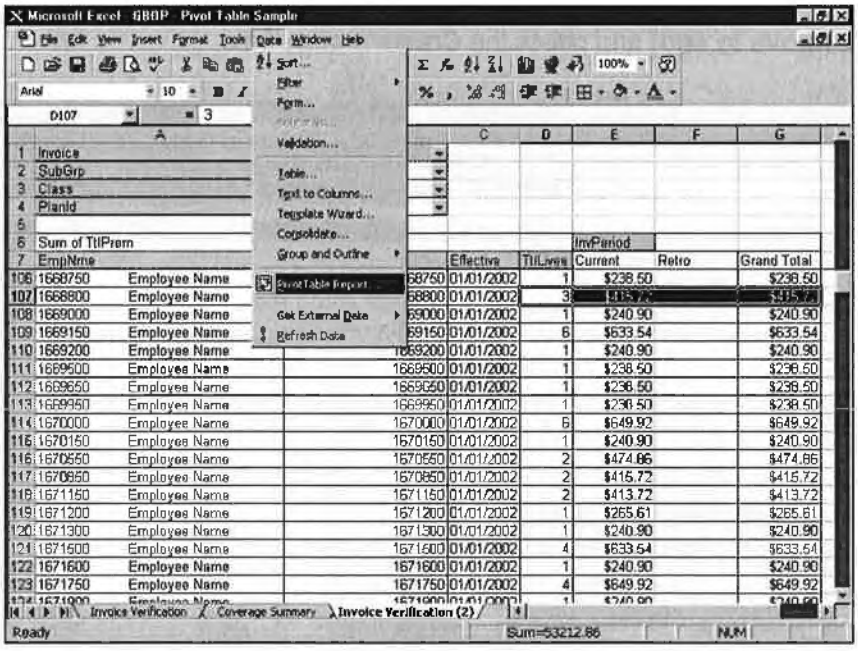
2. Select **(move to end)** and check the **Create a copy** box.



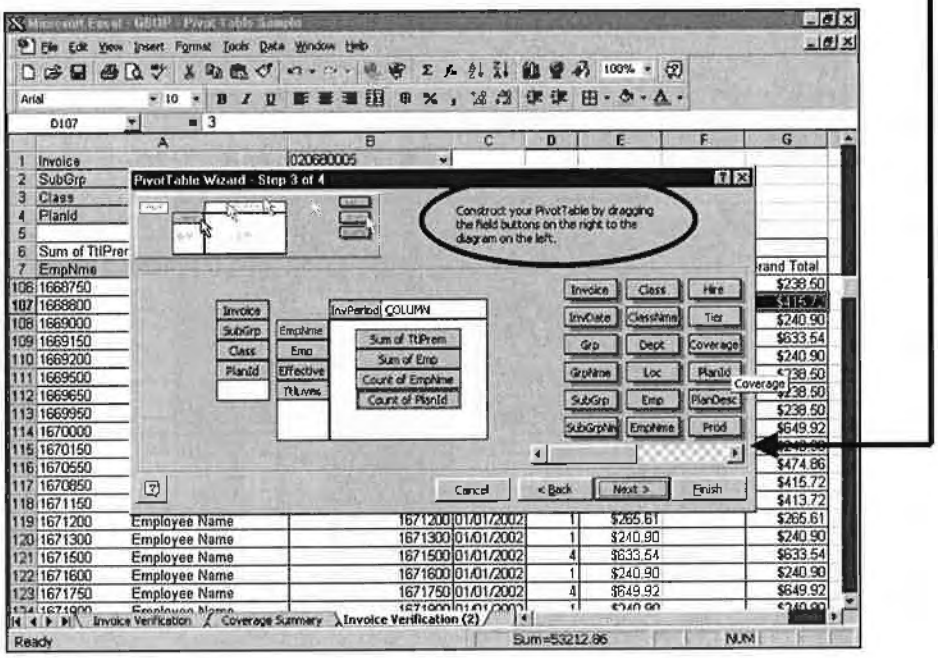
3. An Invoice Verification (2) sheet will now be available to use to create a new report.



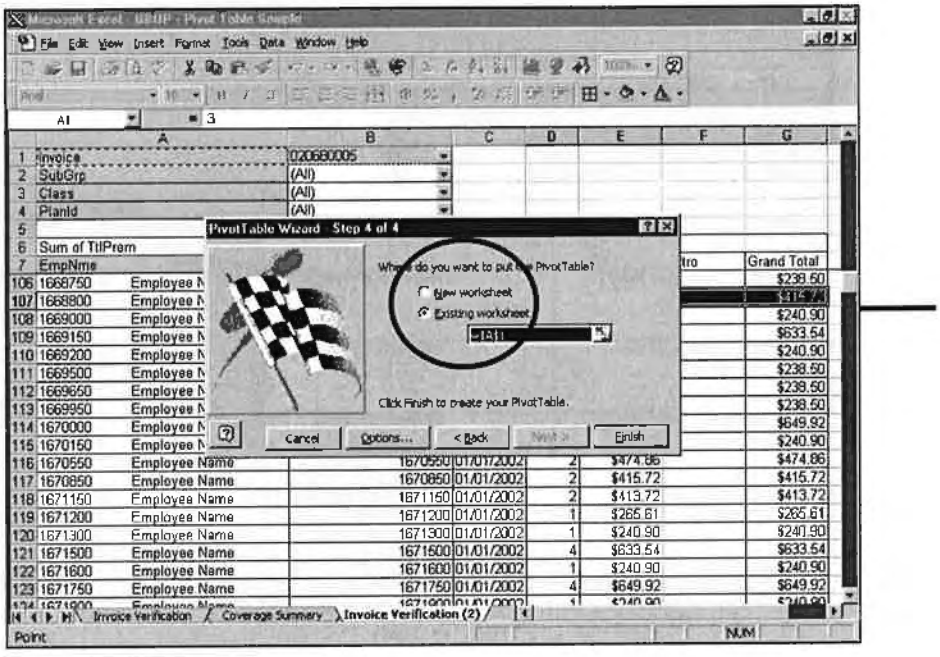
4. Click in a cell with premium information. From the menu, select **Data...Pivot Table Reports**.



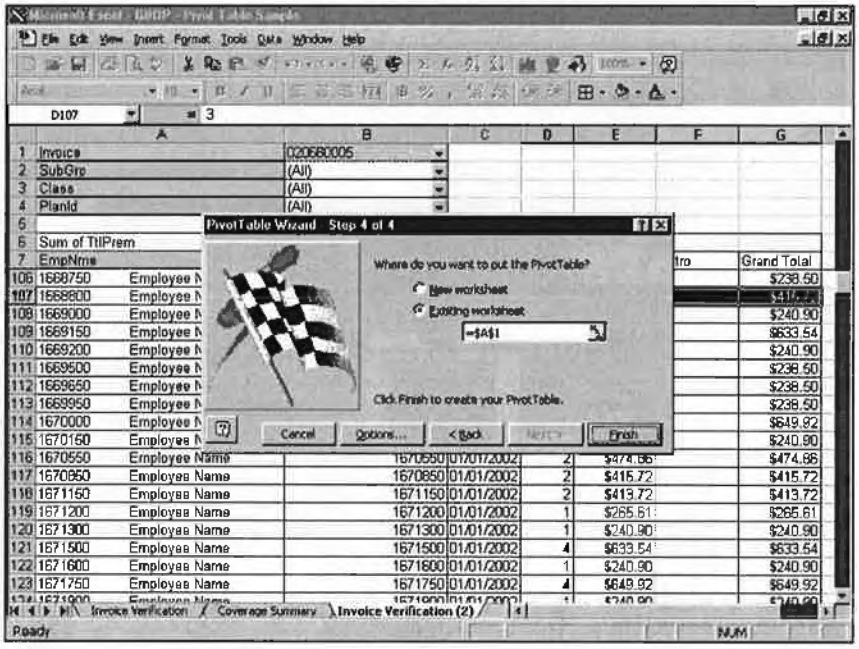
5. The Pivot Table Wizard will guide the user through the steps. Use the horizontal scroll bar to find additional field buttons.



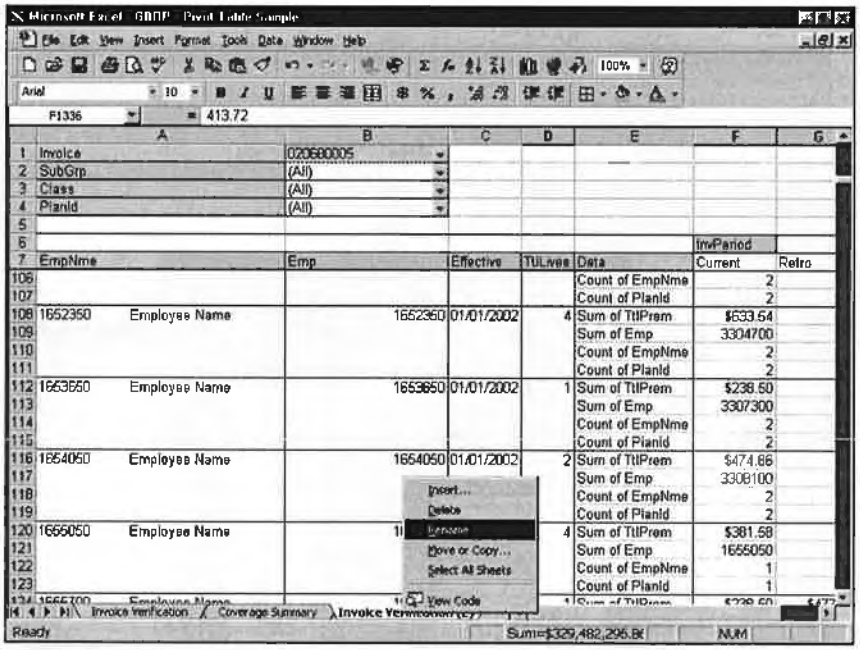
6. After the applicable field buttons have been dragged into the report grid, click on **Next.**



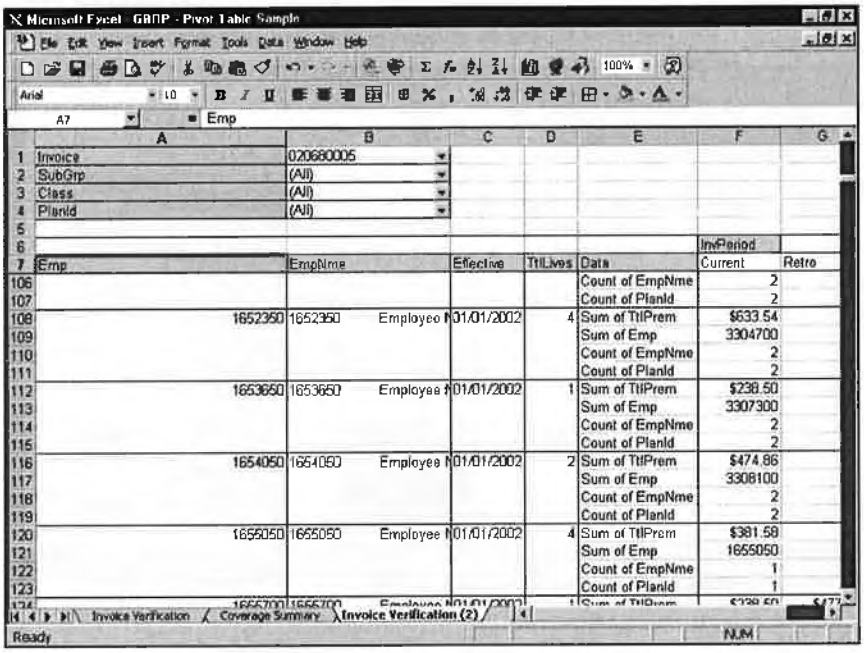
7. Click on the **Finish** button to complete the wizard.



8. The new report information will now display. To rename this worksheet, right click on the Tab and select **Rename**.



9. The column information can be rearrange to meet the user's needs. Click and drag the column to the desired location. In the example below, the Emp column was moved before the EmpName column. Again, it is best to make a copy of the original sheet prior to rearranging the columns to avoid losing any of the information.

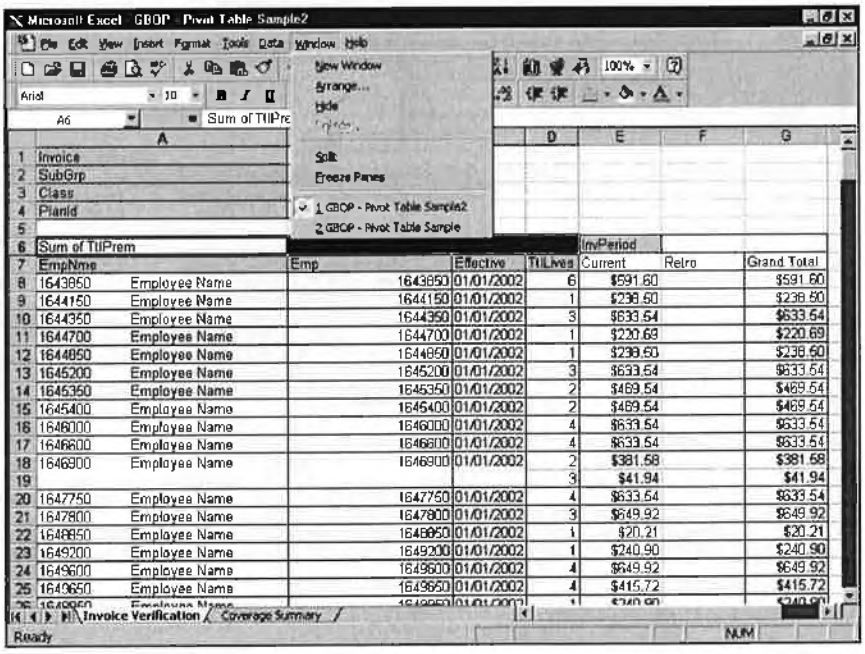


	A	B	C	D	E	F	G
1	Invoice	020680005					
2	SubGrp	(All)					
3	Class	(All)					
4	PlanId	(All)					
5							
6						InvPeriod	
7	Emp	EmpNme	Effective	TtlLives	Data	Current	Retro
106					Count of EmpNme	2	
107					Count of PlanId	2	
108	1652350	1652350 Employee N	01/01/2002	4	Sum of TtlPrem	$633.54	
109					Sum of Emp	3304700	
110					Count of EmpNme	2	
111					Count of PlanId	2	
112	1653650	1653650 Employee N	01/01/2002	1	Sum of TtlPrem	$236.50	
113					Sum of Emp	3307300	
114					Count of EmpNme	2	
115					Count of PlanId	2	
116	1654050	1654050 Employee N	01/01/2002	2	Sum of TtlPrem	$474.86	
117					Sum of Emp	3308100	
118					Count of EmpNme	2	
119					Count of PlanId	2	
120	1655050	1655050 Employee N	01/01/2002	4	Sum of TtlPrem	$381.58	
121					Sum of Emp	1655050	
122					Count of EmpNme	1	
123					Count of PlanId	1	

Invoice Verification / Coverage Summary / Invoice Verification (2) / Ready / NUM

To avoid having to recreate the report for every premium bill, the report can be copied into each subsequent Pivot Table.

1. Open both Pivot Tables. When clicking on **Window** from the menu bar, both worksheets will display.

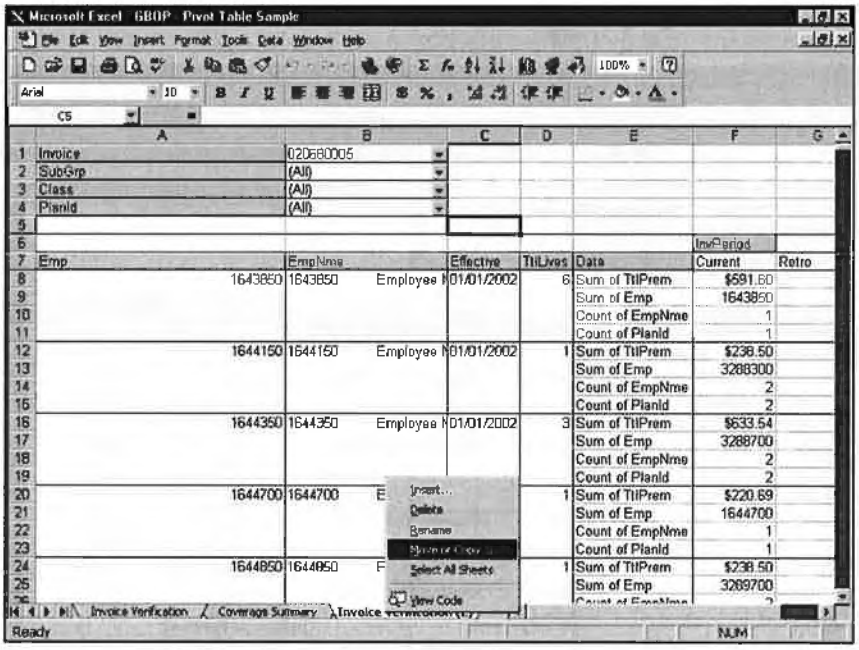


	A	B	C	D	E	F	G
1	Invoice						
2	SubGrp						
3	Class						
4	PlanId						
5							
6	Sum of TtlPrem				InvPeriod		
7	EmpNme	Emp	Effective	TtlLives	Current	Retro	Grand Total
8	1643850 Employee Name	1643850	01/01/2002	6	$591.60		$591.60
9	1644150 Employee Name	1644150	01/01/2002	1	$236.50		$236.50
10	1644350 Employee Name	1644350	01/01/2002	3	$633.54		$633.54
11	1644700 Employee Name	1644700	01/01/2002	1	$220.69		$220.69
12	1644850 Employee Name	1644850	01/01/2002	1	$236.50		$236.50
13	1645200 Employee Name	1645200	01/01/2002	3	$633.54		$633.54
14	1645350 Employee Name	1645350	01/01/2002	2	$469.54		$469.54
15	1645400 Employee Name	1645400	01/01/2002	2	$469.54		$469.54
16	1646000 Employee Name	1646000	01/01/2002	4	$633.54		$633.54
17	1646800 Employee Name	1646800	01/01/2002	4	$633.54		$633.54
18	1646900 Employee Name	1646900	01/01/2002	2	$381.58		$381.58
19				3	$41.94		$41.94
20	1647750 Employee Name	1647750	01/01/2002	4	$633.54		$633.54
21	1647800 Employee Name	1647800	01/01/2002	3	$649.92		$649.92
22	1648850 Employee Name	1648850	01/01/2002	1	$20.21		$20.21
23	1649200 Employee Name	1649200	01/01/2002	1	$240.90		$240.90
24	1649600 Employee Name	1649600	01/01/2002	4	$649.92		$649.92
25	1649650 Employee Name	1649650	01/01/2002	4	$415.72		$415.72

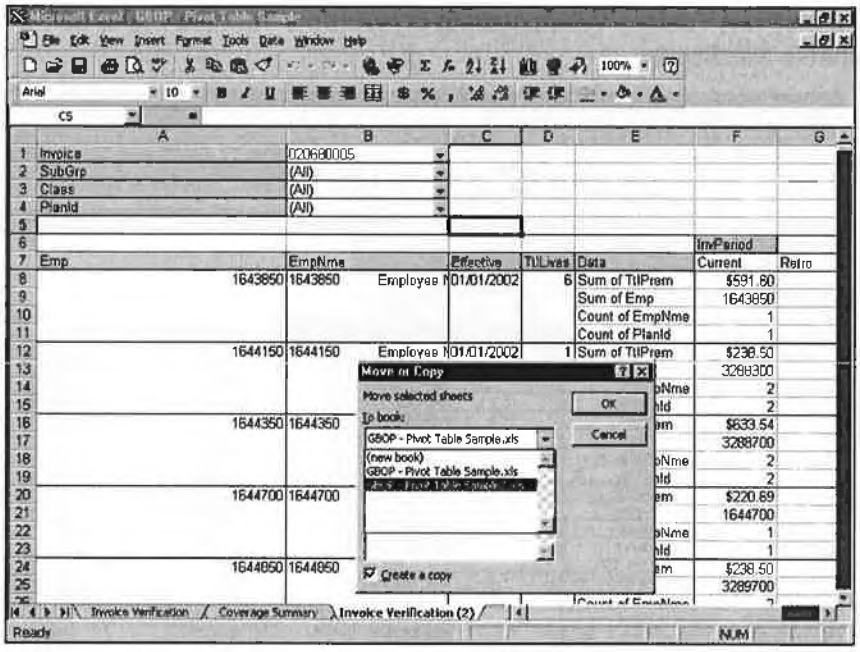
Window menu: New Window, Arrange..., Hide, Unhide..., Split, Freeze Panes, 1 GBOP - Pivot Table Sample2, 2 GBOP - Pivot Table Sample

Invoice Verification / Coverage Summary / Ready / NUM

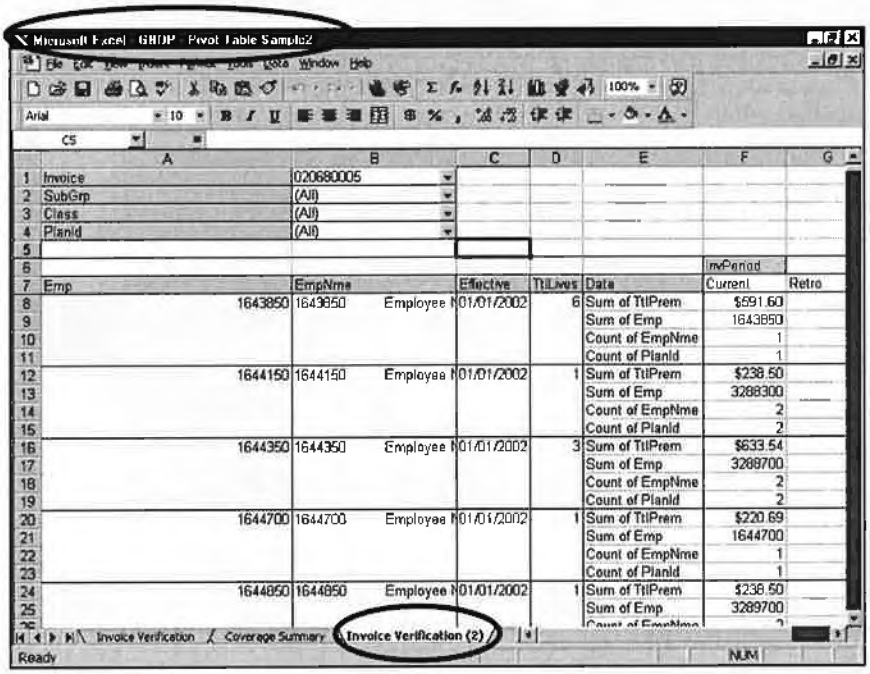
2. To copy the report to the new Pivot Table, right click on the appropriate worksheet tab in the first table. Select **Move or Copy**.



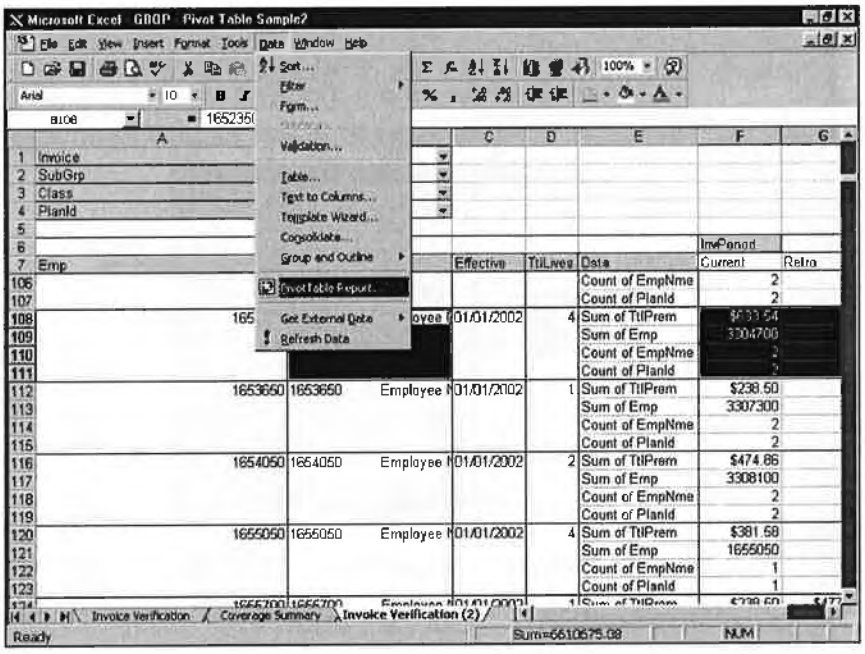
3. Select the new table from the **To book** drop down menu. Be sure to check the **Create a copy** box.



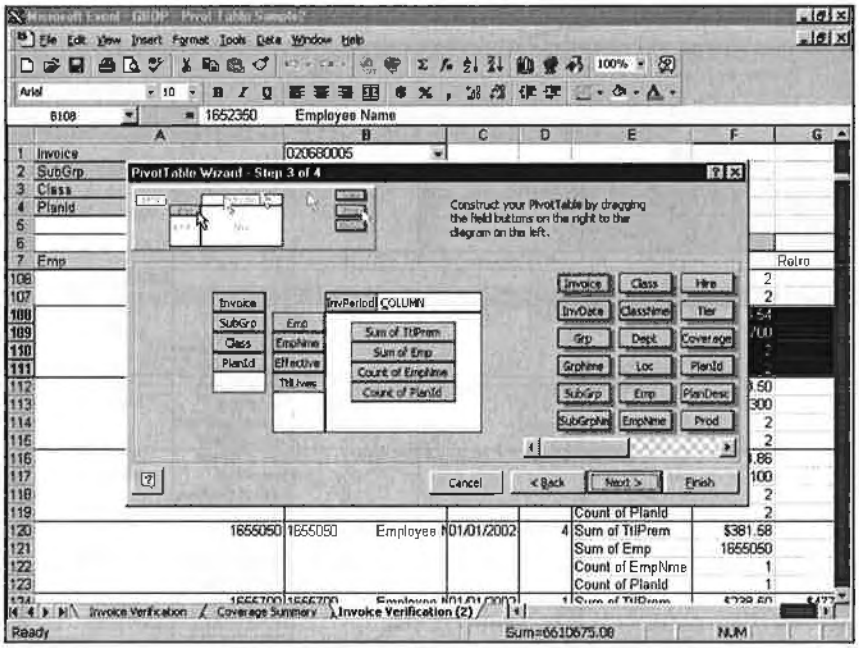
4. The report will now be part of the new Pivot Table, but it is still drawing the data from the previous premium bill.



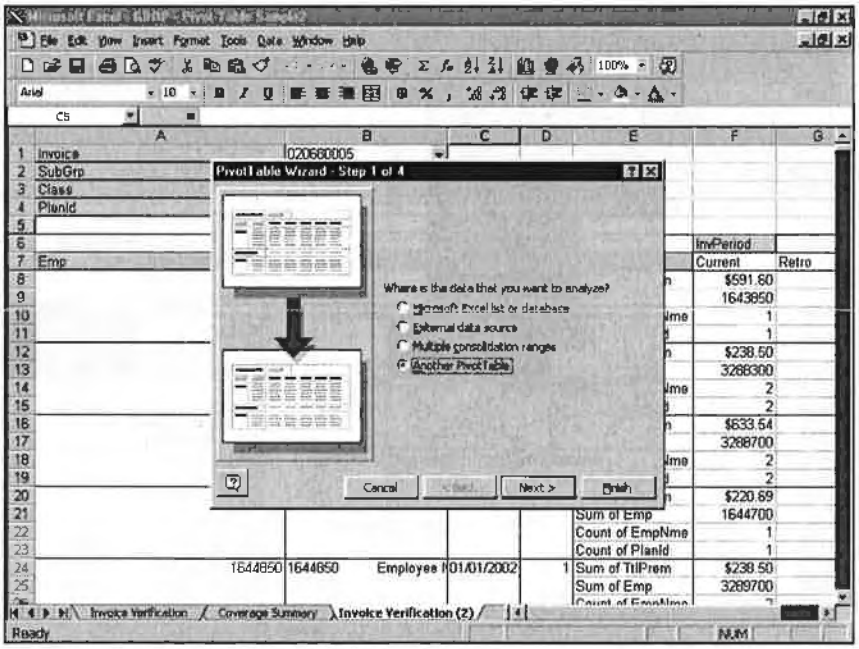
5. The Pivot Table needs to be redirected to the current data. Click into a cell within the report. **Select Data...Pivot Table Report.**



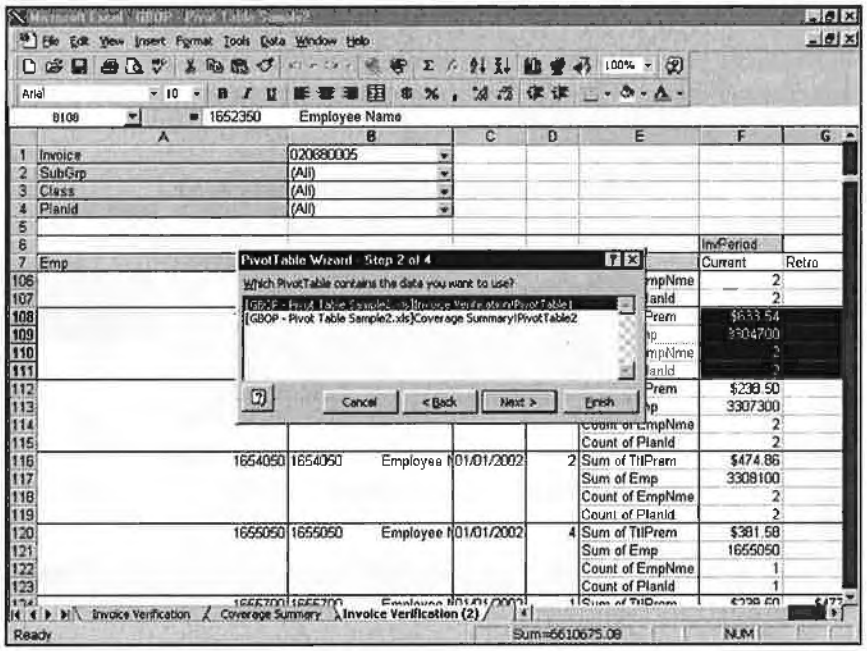
6. The following window will display.



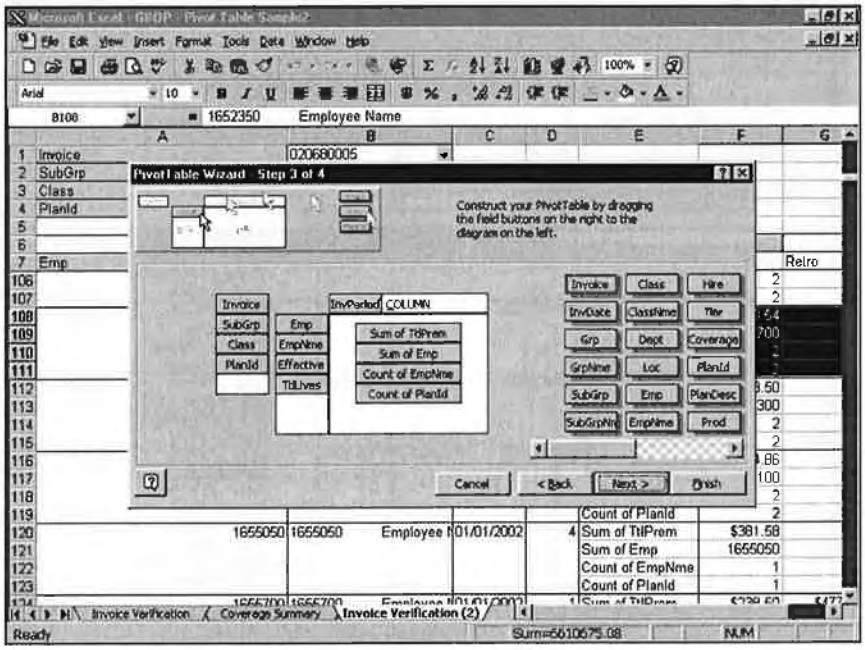
7. Press the **<Back** button (twice) until **Step 1 of 4** is displayed. The Pivot Table Wizard will ask '**Where is the data you want to analyze?**' Select **Another Pivot Table**, then press **Next**.



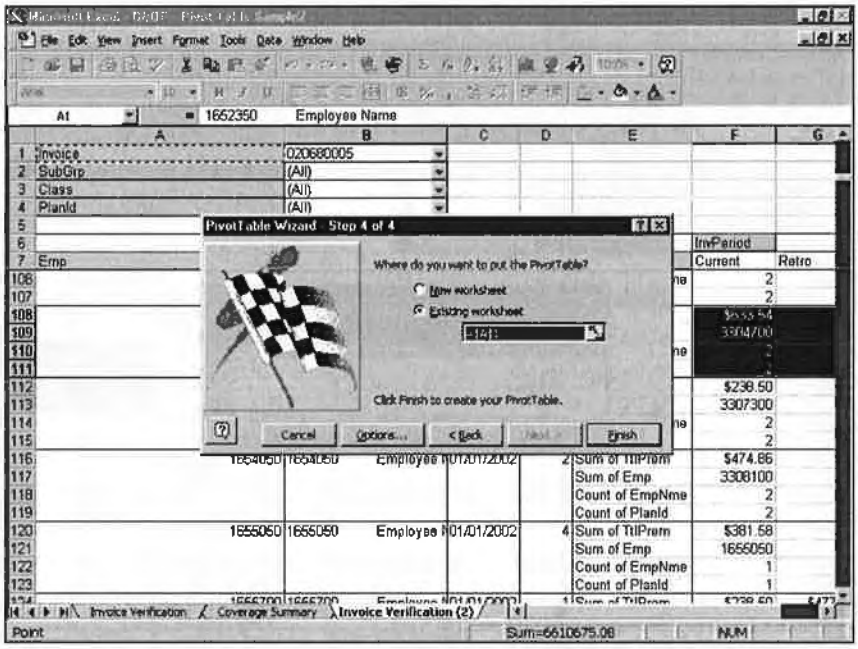
8. The Wizard will display the options. Select the applicable worksheet. In this example we created the report from the Invoice Verification sheet. Press Next.



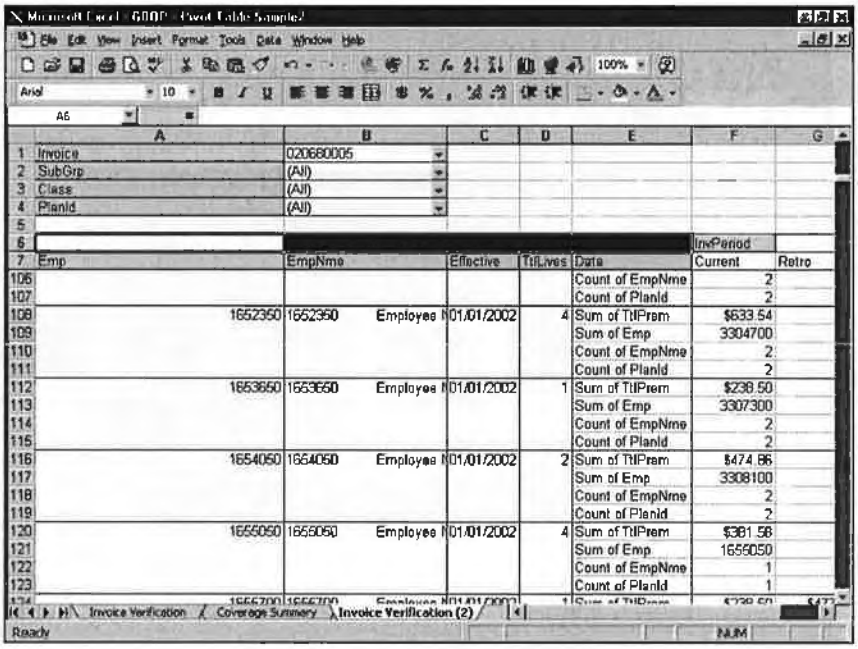
9. The Wizard will display the report data. Press Next.



10. Press Finish to complete the Pivot Table Wizard.



11. The information in the report will now reflect the current billing information.



Member Enrollment Materials

Are You Ready for Enrollment?

Best Practice Timeline To Ensure Success From Mutual of Omaha

Achieve unparalleled participation rates by offering a combination of group meetings supported by online enrollment tools.* Mutual of Omaha's turnkey package of services and communication tools make it easy.

Pre-Enrollment Phase:

Our customizable documents let employees know which benefits are being offered, when and where to sign up. These may include posters, flyers, newsletter articles and email campaigns.

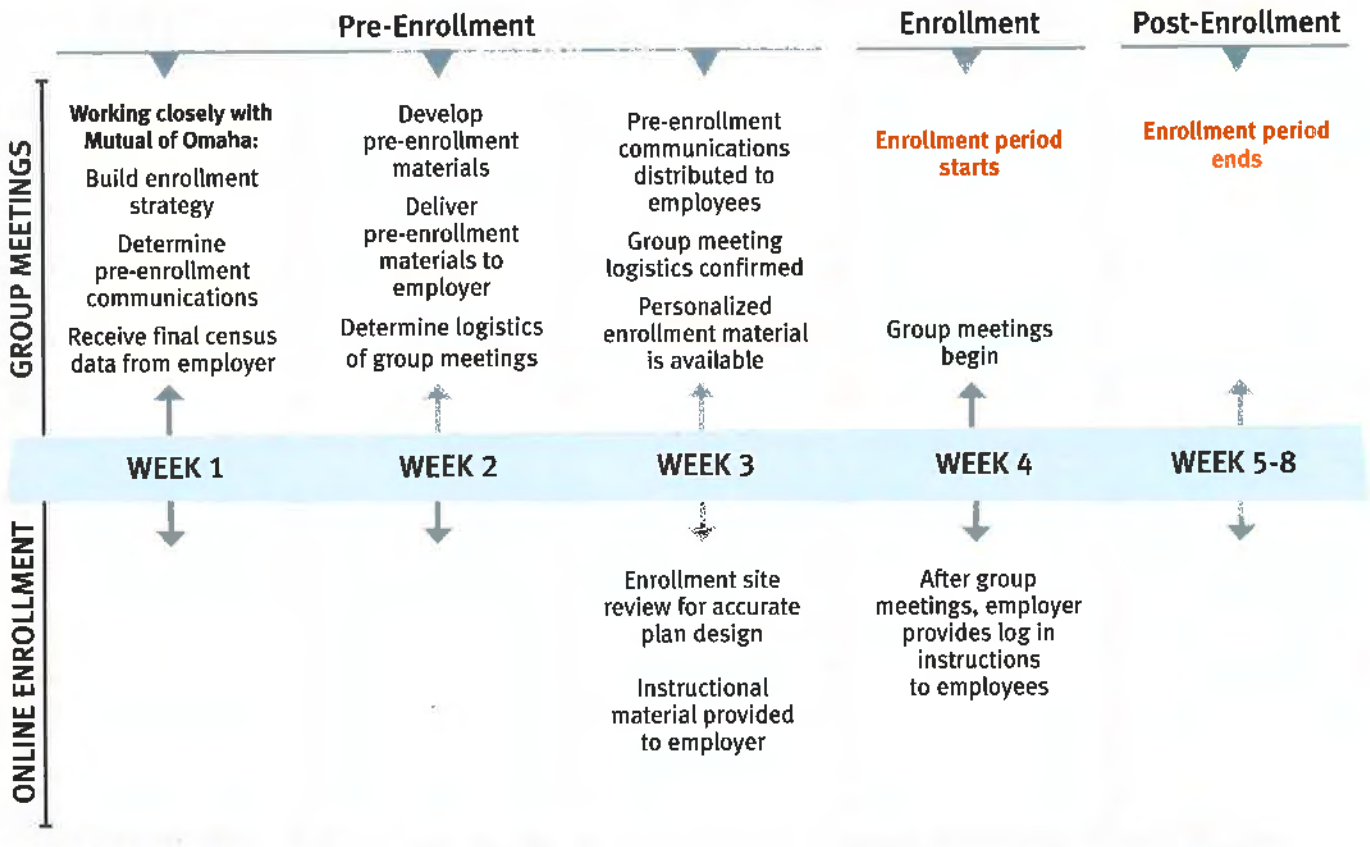
Enrollment Phase:

To get the results you're seeking, begin by holding group meetings where employees receive personalized informational enrollment kits with rate tables and enrollment forms. As a follow-up to group meetings, provide a link to our online enrollment system. This ensures that employees who cannot attend the meeting or are in remote locations get the same opportunity to learn about and enroll for coverage. Meeting support can be provided by professional Mutual of Omaha enrollers, including bilingual support.

Post-Enrollment Phase:

A dedicated service team is available to provide support for benefits information, eligibility, billing and issue resolution.

Example: This enrollment campaign timeline includes both group meetings followed by online enrollment.



**It is not required that enrollment include both online tools and group meetings; however, you will achieve the greatest success with a combined approach.*

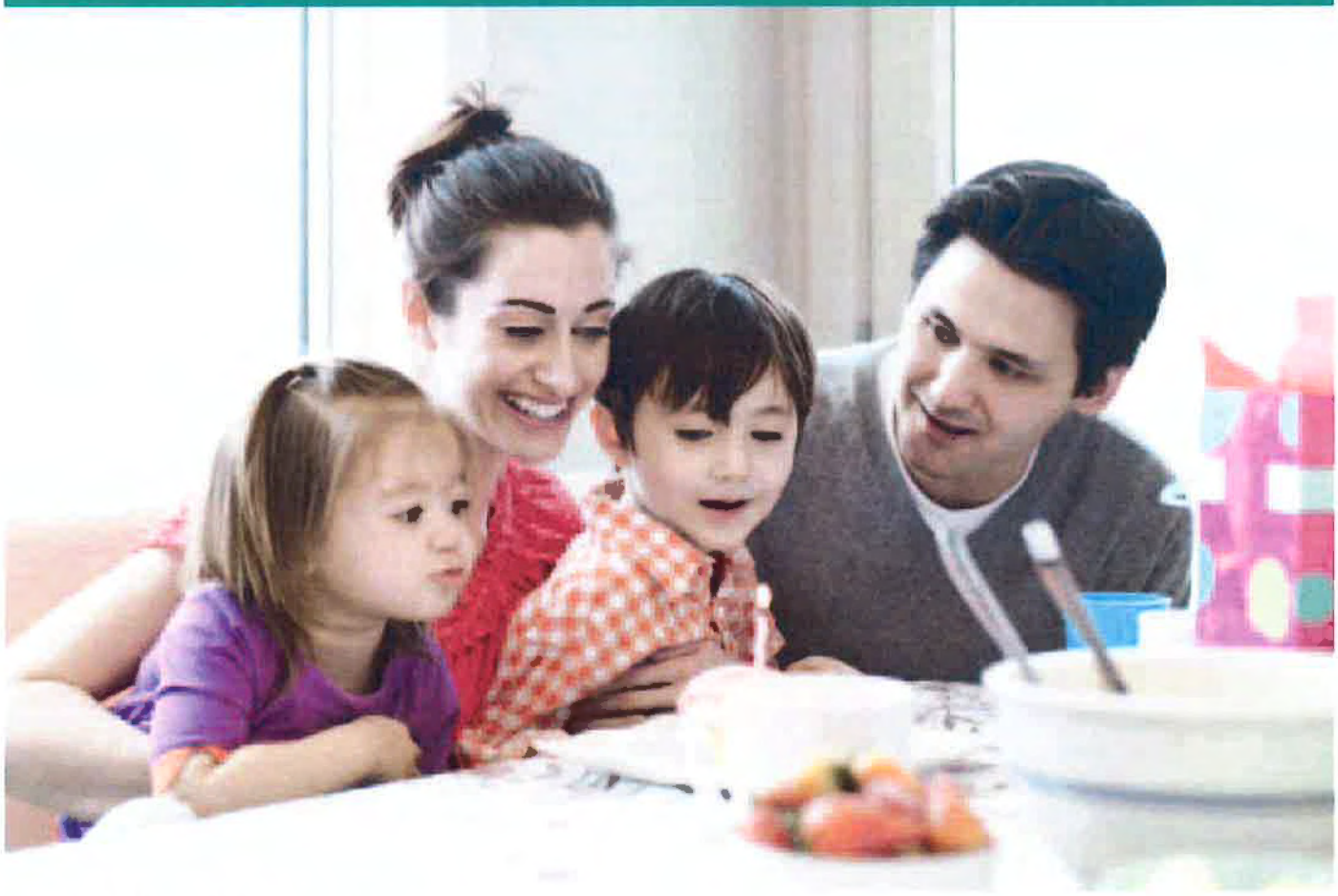
IMPORTANT – Timeline is compromised when final census data is not received.

MUGC9467

› ABC, Inc.

Mutual of Omaha

Important Benefits Information



Enrollment Information for:

LifeAD&D
Voluntary LifeAD&D

› Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of ABC, Inc., you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
Life Insurance Benefit Amount	For You: $25,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	50% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $12,500.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.

Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha
AGE REDUCTIONS AND EXCLUSIONS	
Insurance benefits and guarantee issue amounts are subject to age reductions: - At age 70, amounts reduce to 65% - At age 75, amounts reduce to 50% Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling. Please contact your employer if you have questions prior to enrolling.	

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 70, amounts reduce to 65%
  - At age 75, amounts reduce to 50%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of ABC, Inc., you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES	Minimum	Guarantee Issue	Maximum
For You	$15,000	5 times annual salary, up to $135,000	$250,000, in increments of $5,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $50,000	100% of employee's benefit, up to $125,000
Children	$5,000	100% of employee's benefit	100% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For you and your spouse: The Principal Sum amount is equal to the amount of life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principal Sum.
FEATURES	
Living Care/ Accelerated Death Benefit	50% of the amount of the life insurance benefit is available to you and your spouse if terminally ill, not to exceed $100,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (information about your health).
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 70, amounts reduce to 65%
- At age 75, amounts reduce to 50%

Spouse coverage terminates at age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life and AD&D Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**	**$55,000**	**$60,000**
0 - 29	$1.52	$2.02	$2.53	$3.03	$3.54	$4.04	$4.55	$5.05	$5.56	$6.06
30 - 34	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	$5.04	$5.60	$6.16	$6.72
35 - 39	$1.98	$2.64	$3.30	$3.96	$4.62	$5.28	$5.94	$6.60	$7.26	$7.92
40 - 44	$2.75	$3.66	$4.58	$5.49	$6.41	$7.32	$8.24	$9.15	$10.07	$10.98
45 - 49	$4.13	$5.50	$6.88	$8.25	$9.63	$11.00	$12.38	$13.75	$15.13	$16.50
50 - 54	$5.81	$7.74	$9.68	$11.61	$13.55	$15.48	$17.42	$19.35	$21.29	$23.22
55 - 59	$9.48	$12.64	$15.80	$18.96	$22.12	$25.28	$28.44	$31.60	$34.76	$37.92
60 - 64	$17.43	$23.24	$29.05	$34.86	$40.67	$46.48	$52.29	$58.10	$63.91	$69.72
65 - 69	$26.93	$35.90	$44.88	$53.85	$62.83	$71.80	$80.78	$89.75	$98.73	$107.70
70 - 74	$44.52	$59.36	$74.20	$89.04	$103.88	$118.72	$133.56	$148.40	$163.24	$178.08
75 - 79	$76.34	$101.78	$127.23	$152.67	$178.12	$203.56	$229.01	$254.45	$279.90	$305.34
80 - 84	$159.27	$212.36	$265.45	$318.54	$371.63	$424.72	$477.81	$530.90	$583.99	$637.08
85 - 89	$256.88	$342.50	$428.13	$513.75	$599.38	$685.00	$770.63	$856.25	$941.88	$1,027.50
90+	$404.99	$539.98	$674.98	$809.97	$944.97	$1,079.96	$1,214.96	$1,349.95	$1,484.95	$1,619.94

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your spouse's age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0 - 29	$0.51	$1.01	$1.52	$2.02	$2.53	$3.03	$3.54	$4.04	$4.55	$5.05
30 - 34	$0.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	$5.04	$5.60
35 - 39	$0.66	$1.32	$1.98	$2.64	$3.30	$3.96	$4.62	$5.28	$5.94	$6.60
40 - 44	$0.92	$1.83	$2.75	$3.66	$4.58	$5.49	$6.41	$7.32	$8.24	$9.15
45 - 49	$1.38	$2.75	$4.13	$5.50	$6.88	$8.25	$9.63	$11.00	$12.38	$13.75
50 - 54	$1.94	$3.87	$5.81	$7.74	$9.68	$11.61	$13.55	$15.48	$17.42	$19.35
55 - 59	$3.16	$6.32	$9.48	$12.64	$15.80	$18.96	$22.12	$25.28	$28.44	$31.60
60 - 64	$5.81	$11.62	$17.43	$23.24	$29.05	$34.86	$40.67	$46.48	$52.29	$58.10
65 - 69	$8.98	$17.95	$26.93	$35.90	$44.88	$53.85	$62.83	$71.80	$80.78	$89.75

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*	
$5,000	**$10,000**
$0.80	$1.60

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

› Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 30 hours per week.
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

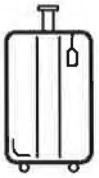
Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 70, amounts reduce to 65%
  - At age 75, amounts reduce to 50%
- Spouse coverage terminates at age 70.
- Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

MUTUAL OF OMAHA INSURANCE COMPANY



Worldwide Travel Assistance and Identity Theft Protection for You and Your Family

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip up to 120 days in length, and more than 100 miles from home.

PRE-TRIP ASSISTANCE*

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport and other documentation needs
- Travel, health advisories and inoculation requirements for foreign countries
- Daily foreign currency exchange rates
- Consulate and embassy locations

IMMEDIATE ATTENTION FOR EMERGENCIES WHILE TRAVELING

While traveling more than 100 miles from home, call Travel Assistance toll-free 24/7 for immediate help from a multi-lingual professional.

**Available at any time, not subject to 100 mile travel radius*

EMERGENCY TRAVEL SUPPORT SERVICES

- **Translation and interpreter services** – 24/7 access to translators or interpreters
- **Locating legal services** – referrals for local attorney or consular offices and help maintaining business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- **Baggage** – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- **Emergency payment and cash** – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- **Emergency messages** – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- **Document replacement** – coordination of credit card, airline ticket, or other documentation replacement
- **Vehicle return** – if evacuation or repatriation is necessary

MUGC9550

Fold Here

Worldwide Travel Assistance

Services available for business and personal travel.
For inquiries within the U.S. call toll free:

1-800-856-9947

Outside the U.S. call collect:

(312) 935-3658

CARRY THIS CARD WITH YOU WHEN YOU TRAVEL

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA, which is not affiliated in any way with the Mutual of Omaha companies.

Fold Here

MEDICAL ASSISTANCE

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

TRAVEL ASSISTANCE PLAN LIMITATIONS

AXA Assistance USA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

Expenses for emergency evacuation, medically necessary repatriation, repatriation of remains, return of dependent children, family or friend transportation arrangement and vehicle return are covered up to $200,000 per person per event.

IDENTITY THEFT

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

EDUCATION AND PREVENTION

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

RECOVERY INFORMATION

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

ASSISTANCE

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance is an added benefit that your employer has purchased for you. You will not see this benefit on your enrollment form.

31219216

› Your Hearing Discount Program

PROGRAM BENEFITS INCLUDE

- **Custom hearing solutions** – we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers
- **Risk-free 60-day trial** – 100 percent money-back guarantee on hearing aid purchase
- **Hearing aid low price guarantee** – if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5 percent
- **Continuous Care** – one year free follow-up, two years of free batteries and a three-year warranty

ACCESSING YOUR BENEFITS IS AS EASY AS...

1. Call Amplifon at 1-888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

To learn more visit **amplifonusa.com/mutualofomaha**

KEEP THIS CARD FOR FUTURE ACCESS TO:

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

TO ACTIVATE YOUR BENEFIT, CALL 1-888-534-1747 TODAY!

SPECIAL MONEY SAVING OFFER!

Call today for your FREE hearing screening appointment!

Please bring this offer with you to your appointment.

CALL 1-888-534-1747 TODAY!

This is not a medical exam and is only intended to assist with amplification selection.

17517

Will Preparation

SERVICES PROVIDED BY WILLING

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die.

Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

You have access to affordable, online will preparation services provided by Willing.

EASY, AFFORDABLE AND SECURE

Willing uses bank-level security to keep your information safe and secure. In just 10 minutes, you can create a personalized will.

Here's how it works:

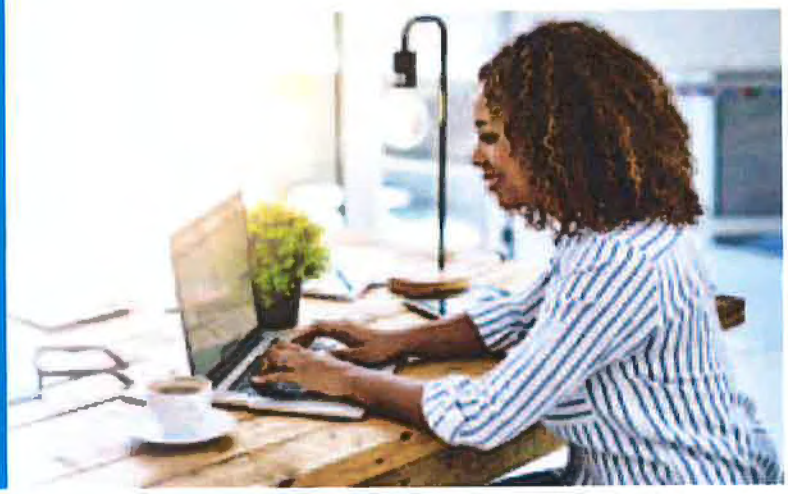
- Log on to www.willing.com/mutualofomaha
- Answer simple multiple choice questions on your computer or smartphone
- Download and print any document instantly
- At time of checkout, enter Mutual55 to receive your affordable Will Preparation package
- Update your information with any major life change, i.e., marriage, divorce, birth of a child
- Plan includes Last Will & Testament, Living Will, Power of Attorney, and Revocable Living Trust or Transfer of Death Deed at an affordable price

Create your will at
www.willing.com/mutualofomaha

Premium Billing Process

Employer Access

New Billing Feature Now Available



Mutual of Omaha understands that administering employee benefits can be complicated and time-consuming. But thanks to a new feature on Employer Access, online billing just got a whole lot easier.

This enhancement provides you and your clients with:

- Improved navigation
- Streamlined user experience
- More accurate billing
- Fast, easy results in real time

To get started, simply log on to Employer Access and access "Finalize My Next Bill" link under the Billing tab. Then follow these steps:

1. Review your bill & update as necessary
2. Update your bill delivery method
3. Review details before submission (you will have the ability to finalize your bill one time only within 31 days of your next bill)

Pretty simple, right?

Along with the Finalize My Next Bill feature, we encourage you to "Go Green" and enroll in online billing so you can pay your bill online. It's as easy as:

1. Go to Employer Access
2. Select the Billing tab
3. Under "My Bill," select "Paperless" as your Delivery Method

Contact me to learn more.

Valued Employee Benefits Partner

Mutual of Omaha

451535

Billing Type Comparison

As a Mutual of Omaha Insurance Company customer, you have a choice in your billing type: List Billing or Self-Administered Billing. The grid below compares the two options to help you determine the best billing type for your company.

Note: List Billing is required for Dental and Groups under 50 covered employees. We recommend all groups under 200 covered employees utilize the List Billing option.

	List Bill	Self-Administered
Billing Type Summary	Detailed invoice reflecting specific coverage and amounts by employee enrolled in the plan is provided.	Summary of total lives, volume and premium by product is provided to Mutual of Omaha. Employee specific information is not included.
Billing Statements	Mutual of Omaha will prepare your billing statements with a complete accounting of all current payments and charges, as well as prior credits. Billing may be broken out by subgroups.	Mutual of Omaha will provide a blank Billing Detail Form to assist you in providing a comprehensive number of covered lives, volume and premium.
Online Services	▪ Employee and/or dependent enrollment & terminations ▪ Evidence of Insurability prepopulated applications ▪ On demand and standard reporting, and more	• Online premium payments • Ability to provide billing detail online
Enrollment/ Changes	You are responsible for communicating enrollment additions, terminations and changes to Mutual of Omaha via phone, email or online.	You are responsible for keeping detailed enrollment records, which are only reported to Mutual of Omaha upon renewal or by request; a signed enrollment form also must be submitted with any claim form.
Monthly Enrollment Submission	You will need to review the Billing Statement for accuracy and reconcile it with your records. Remit payment as billed; in the event of a discrepancy, notify Mutual of Omaha immediately.	Not applicable
Monthly Premium Submission*	You may pay your premium online through our secure plan administration website or mail in your premium along with the Premium Remittance Slip.	Premium submission is the same as List Bill (noted at left). However, the Billing Detail must also be provided (either online, via fax or email) at same time as payment.

**Other billing frequencies available*

Mutual of Omaha

Mutual of Omaha

Why Mutual of Omaha

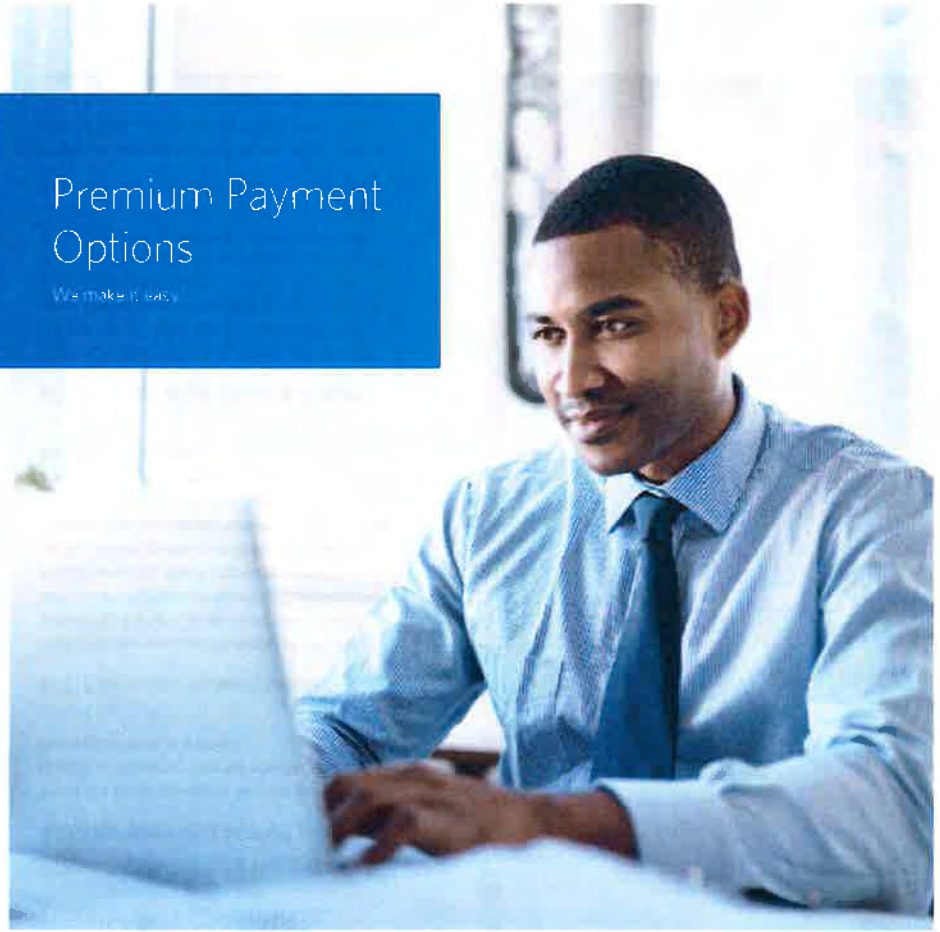
For more than a century, Mutual of Omaha has been committed to listening to our customers and helping them through life's transitions by providing an array of insurance, financial and banking products.

MutualofOmaha.com

INSURANCE | Medicare Supplement | Life | Employee Benefits

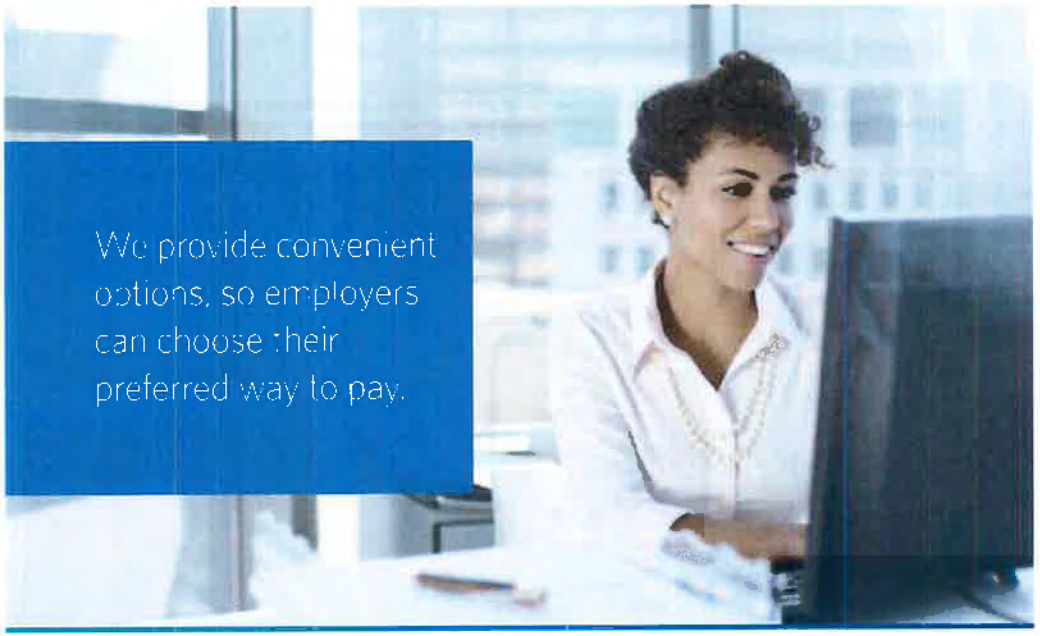
Premium Payment Options

We make it easy.



Mutual of Omaha

347075



We have two preferred ways for employers to pay their premiums: online through Employer Access or via mail with a remittance slip. Depending on the employer's circumstances and needs, one method may be a better fit than the other.

Here are a few of the highlights for each option:

Online – Employer Access

For virtually all employers, this is the easiest and quickest way to pay premiums. Plus, it has some other attractive features:

- It's environmentally friendly
- It's safe and secure
- The payment is attached to the correct account via a secure login

Traditional Mail – Remittance Slip

For some, the traditional method of mailing their premium payments may be more suitable. Here are a few things to consider if you choose this method:

- For each group, you may have multiple invoices and remittance slips — it is preferred that employers pay each bill group separately, rather than combining payments.
- Including the remittance slip with the scan line is important — our bank uses it to properly apply your premium. When the remittance slip is not included, there will be a delay in the premium being applied to your account.

Details and Definitions

EFT vs ACH – What's the difference, and how does that impact me?

These two terms are similar because they both refer to types of electronic transactions that move money from one account to another.

EFT: Electronic Funds Transfer

With EFT, the money is initiated by the PH bank and sent to our bank, so this is a bank to bank transaction. Payments made via EFT are deposited the following day. These payments sometimes need to be reviewed to determine the applicable group number. They are typically handled within one day, but can sometimes take two days or more. As a result, payments are not always associated to a specific group right away.

ACH: Automated Clearing House

When a payment is made via Employer Access, the user is associated to a specific group. As a result, payments are immediately associated to the appropriate group. Payments are sent through a file to the bank once a day, so there could be a one-day delay before these payments appear in the billing system. Payments made via Employer Access are automated and require no contact from our reps.

Whether employers choose to pay their premium through Employer Access or with remittance slips, these two convenient options let employers pick the method that best suits their needs.

Employer Access

Claims Status Reporting Enhancements

Claim status reporting in Employer Access just got a whole lot easier. We heard your feedback and made several enhancements – all designed to provide a more efficient experience.

Enhancements Include

Instant access to information
No more 15-minute wait!

Simplified navigation
Claim status reports are now located in one spot, under the new Claims Reports tab

Streamlined reporting
We've eliminated more than 25 custom reports and created new simplified claim status reports

Excel exporting capabilities
Quickly generate customized reports and export them to Excel

Customizable views
Easily sort information and set filters

As always, we remain committed to improving our products and services so we can continue to meet yours and your clients' needs.

Contact your Mutual of Omaha sales representative to learn more.

*97% of our clients say we're easy to do business with.**

Valued Employee Benefits Partner

Mutual of Omaha

*Source: Mutual of Omaha commissioned the Center for Strategy Research, Boston, to conduct a client satisfaction survey of a subset of group customers of Mutual of Omaha Insurance Company and its affiliates. The two-month survey concluded in April 2016. Survey results are limited to those expressing an opinion.

451573

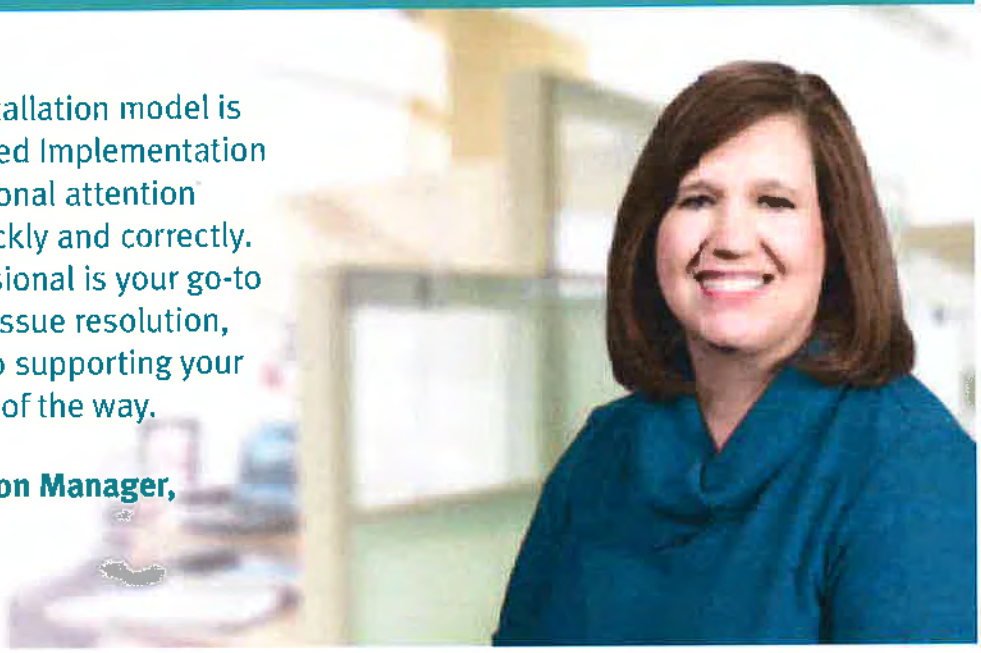
Implementation Workplan

› Personal Attention from Start to Finish

You need to focus on building your business, so let Mutual of Omaha Insurance Company ease your mind while we establish your benefits plan.

Our proven business installation model is simple: Assign a dedicated Implementation Manager to provide personal attention and set up your plan quickly and correctly. This experienced professional is your go-to contact for support and issue resolution, and they're committed to supporting your benefits plan every step of the way.

Meet your Implementation Manager, Janet Middleton.



Janet works directly with you to:

- **Ensure paperwork is complete and accurate**
- **Track progress and keep you informed**
- **Address and resolve issues as they arise**
- **Coordinate all aspects of installation**
- **Provide group numbers within five business days**
- **Distribute plan booklets and first billing statement within 20 business days**

With over ten years of experience in the insurance industry you can be sure you can count on Janet to understand the true intent of the benefit summary you are trying to acheive. "I lask a lot of questions to be sure I completely understand the intent of the benefit set up."

Janet Middleton
402-351-6009
janet.middleton@mutualofomaha.com

Implementation Experience

PERSONAL ATTENTION FROM START TO FINISH

Mutual of Omaha

Our number one priority is to make it easy for you to do business with us. We understand you need case set up to be accurate, timely and hassle free. You can trust that your dedicated Implementation Manager has the knowledge and experience to get it right the first time, so you may have some peace of mind.

Submit New Group

After your benefits have been confirmed, your paperwork is sent to your implementation manager.

Receive Group ID

5 Business Days

Your Group ID is issued within 5 business days, after we have received:

- Signed master application
- Eligible enrollment data

Access Initial Contract Documents and Invoice

20 Business Days

Your initial contract documents and invoice are available online within 20 business days, after we have received:

- New customer verification guide
- Final enrollment data

Service Welcome Contact

Your dedicated service team will reach out shortly after you receive your initial contract documents and invoice to answer any questions you may have.

Conversion Form

› Conversion Process

If your group coverage ends or reduces, you have the opportunity to convert your employer sponsored life insurance policy, or voluntary life insurance policy, to an individual whole life policy. You may convert an amount up to your previous coverage level without medical underwriting.

FOLLOW THESE STEPS TO SUCCESSFULLY CONVERT YOUR LIFE INSURANCE:

1. Obtain a Group Life Conversion Form from your employer or at mutualofomaha.com/customer-service
2. Ensure your employer completes the section "Information to be Completed by the Personnel Office"
3. Complete remaining sections of the application form
4. Attach check or money order for the premium payment (see application to determine amount)
5. Send completed form and premium payment within **31 days** of group insurance ending or reducing to the address on the application
6. Receive notification from us once your request has been processed

For questions regarding eligible insurance amounts, please contact your Benefits Administrator.

Other questions about the conversion process should be directed to us at (800) 826-8054.

Life Conversion Coverage

Life Goes on with Group Conversion

Your group life insurance has been valuable protection for you and your family. Now that it will be terminated, you may wish to convert this important coverage to an individual policy. This information has been prepared to help you take advantage of your right to continue your protection.

About Life Conversion Coverage

Life Conversion Coverage is individual permanent life insurance issued without evidence of insurability.

Life Conversion Coverage can be obtained when your life insurance under the group policy ends. Your group certificate will describe when conversion coverage is available to you, and will show the amount of coverage you can convert.

Conversion coverage will be issued without evidence of good health, provided:
(a) you complete the attached application,
(b) you enclose a check or money order for the first premium payment and
(c) these items are forwarded to us within 31 days after your group insurance ends.

Your conversion policy will be effective on the 31st day after your group insurance ends. During this 31-day period, you remain covered under the continued coverage provision of your group certificate.

You may apply for an amount that is not more than the amount of your current group insurance coverage (this is your maximum). You may elect coverage in $1,000 increments up to your maximum.

The individual policy is Whole Life Express Insurance, which provides a level benefit throughout your lifetime. Premiums for this coverage are payable while living until the policy anniversary following age 100.

Premium rates are shown in the table that follows. If premium payments are discontinued, you may:
(a) receive any existing cash value or
(b) use the cash value to purchase extended term insurance or a reduced amount of paid-up life insurance.

For additional information or premium rates on conversion coverage, please write or call us at:

Attn: Group Policy Services, Group Conversion
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: 1-800-826-8054

To Apply for Life Conversion Coverage

In order to apply for life conversion coverage, you must do the following:

1) Complete the Life Conversion Application that follows. Use black or blue ink, or a typewriter. Write clearly and do not erase – any corrections should be crossed out and initialed by you. Answer each question fully – do not use dashes or ditto marks.

2) Make sure the section entitled "Information to be Completed by the Personnel Office" is completed by the employer or administrator of the group policy.

3) Attach your check or money order payable to United of Omaha Life Insurance Company for the first annual or semiannual premium payment.

4) Send your premium payment and completed application to the above address within 31 days after your group insurance ends.

Privacy Notice: *When United of Omaha Life Insurance Company evaluates an application for life conversion coverage, only the information on the application is reviewed. This information, and other information we may later collect to administer coverage, may sometimes be disclosed without your express authorization. We have a procedure which allows you to review and amend any information we collect about you – other than information relating to a claim, lawsuit or criminal proceeding. If you would like to know more about our information practices, please write us at the address shown above.*

Calculating The Premium

The premium amounts in the table below are per $1,000 of coverage. Calculate your annual and/or semiannual premium in the calculation worksheet, following the steps and example below.

To calculate annual and semiannual premium:

1) Divide your desired death benefit amount by 1,000.
2) Locate your age group and gender on the table below to identify the premium rate per thousand.
3) Multiply #1 by #2 above.
4) Add $36 for the annual policy fee to obtain the **annual premium** for the coverage.
5) Multiply the annual premium by .52 to obtain **the semiannual premium** for the coverage.

Issue Age	Male	Female
0-4	$6.80	$6.10
5-9	$7.70	$6.90
10-14	$8.80	$7.80
15-19	$10.00	$9.00
20-24	$17.00	$12.50
25-29	$21.00	$15.00
30-34	$25.00	$17.50
35-39	$30.00	$20.50
40-44	$35.00	$24.00
45-49	$41.00	$30.00
50-54	$46.00	$33.00
55-59	$58.00	$40.00
60-64	$80.00	$51.00
65-69	$111.00	$72.00
70-74	$154.00	$108.00
75-79	$196.00	$149.00
80-84	$238.00	$198.00
85	$304.00	$255.00

Example (Assumes a 50-year-old male with current group life coverage of $20,000.)

20 (Desired coverage amount/$1,000) x $46.00 (Premium rate per thousand) = $920.00 (Premium for coverage) + $36 (Annual policy fee) = $956.00 (**Total annual premium**)

$956.00 (Total annual premium) x .52 = $497.12 (**Total semiannual premium**)

Calculation Worksheet

_____ (Desired coverage amount/$1,000) x _____ (Premium rate per thousand) = _____ (Premium for coverage) + $36 (Annual policy fee) = $_____ (**Total annual premium**)

_____ (Total annual premium) x .52 = _____ (**Total semiannual premium**)

Conversion Application

This application must be completed and mailed within 31 days after your group insurance ends. Mail the conversion to: Attn: Group Policy Services, Group Conversion, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Nebraska 68175.

Life Insurance Section

1 Applicant's Name (First, Middle, Last)

_____

2 Social Security Number

_____

3 Male ☐ Female ☐

4 Age _____ **5** Date of Birth _____ _____ _____
Mo. Day Yr.

6 Residence (Number, Street, City, State, ZIP)

_____

_____

7 Home Phone Number (_____)_____

8 Amount of Insurance $_____
(Show amount in thousands, not greater than the amount you are entitled to convert.)

9 Mode of Premium Payments
☐ Annually ☐ Semiannually

10 Amount Paid with Application

$ _____

11 Beneficiary (Give full name and relationship to applicant)

Primary _____

Contingent _____

Payment will be shared equally by all primary beneficiaries who survive you; if none, it will be shared equally by all contingent beneficiaries who survive you. Unless otherwise stated, you have the right to change the beneficiary.

Group Information Section

1 Group Policyholder _____ Group Policy No._____

2 I have been insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

3 I became insured under the Group Policy: _____ Month _____ Day _____ Year

4 My group insurance terminated: _____ Month _____ Day _____ Year

5 Was termination due to disability? ☐ Yes ☐ No
(If "Yes," give date and cause of disability.) _____

Life Agreements Section

I am applying to United of Omaha for the life conversion coverage shown above. I agree United will not be under any obligation or liability under this application unless:

(1) I have the right to convert the insurance shown above.
(2) The application is made within 31 days after my group insurance ends.

Date _____, _____ State signed in _____

_____
Applicant's Signature

Whole Life Express Policy Form 6879L-0202, or state equivalent. In OK, 6918L-0202. In OR, 6949L-0202. In TX, 6920L-0202.

135L-0682

INFORMATION TO BE COMPLETED BY THE PERSONNEL OFFICE

Group Policyholder _____

Policy No. _____ Phone (_____) _____

Address (Number, Street, City, State, ZIP) _____

Applicant's Name _____

Certificate No. _____

1 The Applicant was insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

2 For what amount of coverage was the Applicant insured? $ _____

3 What is the Applicant's date of birth? _____ Month _____ Day _____ Year

4 When did the Applicant become insured under the Group Policy? _____ Month _____ Day _____ Year

5 The Applicant's coverage was: ☐ terminated on _____ Month _____ Day _____ Year

☐ reduced by $ _____ on _____ Month _____ Day _____ Year

Because of _____

_____

Completed by _____ Signature (Employer or Administrator)

Title _____ Date _____

Proof of Loss

United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Toll Free (800) 775-8805
Fax (402) 997-1835
Email submitgrplife@mutualofomaha.com

Instructions for Filing a Proof of Death Claim Form

Upon the death of an insured employee, plan member or insured dependent, the employer/plan administrator must complete the claim form as indicated and send attachments mentioned below. Be advised that further documentation might be necessary in the future to complete the claim process.

Please submit the required documentation:

1. Proof of Death claim form:

   Part I – Completed by the employer/plan administrator
   Part II – Completed by the beneficiary(ies)

2. Beneficiary Designation form, including beneficiary changes.

3. Original, photocopies or screen-print of enrollment form.

4. Original certified death certificate. If the benefit amount is $200,000 or less, a copy is acceptable.

5. For accidental death benefits, provide the following items, including but not limited to:
   a. Official investigative report (police, accident, fire, FAA, OSHA)
   b. Proof of seatbelt/airbag use, if applicable
   c. Coroner's report or Medical Examiner's report findings and/or toxicology report

6. If the beneficiary is:
   a. An Estate – We require the Letters Testamentary or Letters of Administration appointing the personal representative of the estate
   b. A Trust – We require a copy of the following pages of the trust – Face page of Trust, Trustee or Successor Trustee designation and Signature page of Trust
   c. A Minor – According to state law, a minor lacks capacity to sign a binding release of an insurance contract.

      For this reason, life insurance benefits are not directly payable to a minor beneficiary. The following are options available when the beneficiary is a minor:

      1. UTMA (Uniform Transfer to Minors Act) – UTMA payment may be utilized providing that the benefit amount including interest is under the amount allowed for the minor beneficiary's state of residence.
      2. Guardianship papers – The minor's custodian may obtain formal guardianship papers for the minor's estate. These legal guardianship documents must be obtained prior to the release of the benefit.

7. If the beneficiary has predeceased the insured and no contingent beneficiary is named or the insured did not name a beneficiary:
   a. Payment of the life insurance benefits will be paid in order as specified in the policy provisions of the contract
   b. The surviving heir must complete an Affidavit of Preferential Beneficiary Designation Form, which must be notarized

The Proof of Death claim form should be returned to:

United of Omaha Life Insurance Company
Group Life Claims
Mutual of Omaha Plaza
Omaha, NE 68175-0001
or
Fax number: (402) 997-1835
Email: submitgrplife@mutualofomaha.com

Proof of Death Claim Form

Part I To Be Completed by the Employer or Plan Administrator

The deceased is insured as: ☐ Employee/Member ☐ Spouse ☐ Child

1. Name of deceased _____

   Name of employee/member (If not the deceased person) _____

2. Date of death _____ Date of birth _____ Age _____

3. Social Security number of deceased _____

4. Employee's/member's marital status
   ☐ Single ☐ Married ☐ Widow/widower ☐ Separated ☐ Divorced ☐ Domestic partner relationship ☐ Civil union

5. Amount of insurance: Basic life _____ Basic AD&D _____
   Voluntary life _____ Voluntary AD&D _____
   Supplemental life _____ Voluntary dependent AD&D _____
   Basic dependent life _____ Voluntary dependent life _____

6. Date premium for the above deceased has been paid through _____

7. Date employee's employment or member's membership began: Full time _____ Part time _____

   Annual salary (If salary based) $_____ Date of last salary increase _____

8. Effective date of deceased's insurance with Mutual of Omaha or United of Omaha _____

9-13 required for employee and/or dependent claims.

9. Date on which the employee was last present at work? _____

10. Reason for employee ceasing work
    ☐ Illness (Including disability leave of absence/partial disability) ☐ Leave of absence (Other than disability)
    ☐ Quit ☐ Dismissed ☐ Vacation ☐ Retired (Date) _____ ☐ Layoff ☐ Deceased ☐ Accident

11. Was the employee disabled? ☐ Yes ☐ No

    If yes, date disability began _____ Date partial disability began _____

12. Employee was: (Check all that apply) ☐ Full time ☐ Part time
    ☐ Union ☐ non-Union ☐ Hourly ☐ Salaried ☐ Exempt ☐ non-Exempt ☐ Other (Explain) _____

13. Average hours employee worked per week: _____ Occupation _____ Class _____

14. Name of beneficiary as shown on your records _____ Relationship _____
    Attach enrollment record plus any beneficiary changes (In written or electronic format)

Attach beneficiary designation form plus any beneficiary changes.

We hereby certify that to the best of our knowledge and belief, the above statements are correct and that said deceased's insurance was in force on the date of his or her death.

Group policy number _____ Name of policyholder _____ Date _____

Signature of authorized employer/plan representative _____

Phone number _____ Fax number _____ Email address _____

Part II To Be Completed by Beneficiary*

**If there is more than one beneficiary, each must complete a separate form.*

Name _____
First Middle initial Last

Beneficiary's Social Security number or Taxpayer Identification number _____

Date of birth _____ Home phone _____ Cell phone _____

Address _____

City _____ State _____ ZIP code _____

Email address _____

Name of deceased _____ Relationship to deceased _____

Group policy number of deceased _____

Cause and manner of death, if known _____

If the deceased was an employee/member, fill out the following:

Was the employee/member disabled? ☐ Yes ☐ No If yes, date disability began _____

If you are not the named beneficiary, in what capacity do you make this claim? _____

Does the deceased have any other life insurance coverage with Mutual of Omaha or United of Omaha? ☐ Yes ☐ No

If the deceased was a dependent fill out the following:

Dependent's occupation _____

Was the dependent disabled? ☐ Yes ☐ No

If yes, date disability began _____ Dependent's last day worked _____

Dependent's employer _____ Dependent's employer's phone number _____

Is child ☐ Full-time student ☐ Part-time student

Name & address of school _____
(Street) (City) (State) (ZIP code)

Certification

In order for us to comply with applicable IRS reporting requirements, please complete the following certification:

Under penalty of perjury, I certify that:

a) The statements I have made on this form, including my Taxpayer Identification Number (or the fact that I am waiting for a number to be issued to me), are correct, and
b) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends, or the IRS has notified me that I am no longer subject to backup withholding.
c) I am a U.S. person.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Your signature _____ Date _____

Printed name _____

Authorization To Disclose Personal Information

1. I authorize physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical and dental services to release Personal Information to representatives of United of Omaha Life Insurance Company for:

   Deceased name _____ Deceased date of birth _____

2. Personal Information includes: medical history, mental and physical condition, prescription drug records, alcohol and drug use, financial and occupational information.

3. The Personal Information will be used to evaluate my claim for benefits.

4. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

5. I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

6. This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to: ATTN – Group Life Claims, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175-0001. Any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

7. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

_____ _____

Signature of claimant or individual authorized to represent the deceased

Date

_____ _____

Printed name

Relationship to deceased

Address _____ _____

(Street)

Phone number

_____

(City) (State) (ZIP code)

Coping with Loss

Adjusting to losing a loved one

At times of grief and loss, it's not uncommon to be confused and uncertain about how to proceed.

We asked grief counselors, physicians and financial advisors what advice they would offer friends and clients during this difficult time. Some of their advice follows.

Grief & loss can affect your health

Be careful of your physical well-being, too. Your distress may manifest itself in sleeplessness and loss of appetite, adding to your emotional upset. The physical demands of added responsibilities may also take their toll. So, learn to ask for help and go easy on yourself.

Losing a loved one is one of life's most difficult trials

Each loss, like each relationship, is unique and each grief journey follows its own path and takes its own time. Strong emotions are natural and are a part of the healing process. Accepting those emotions and giving yourself permission to have them are important steps in the journey. Some mourners find solace in support groups or with professional counselors.

Finances

You may face major new financial responsibilities at this time. Not only must you put your own finances in order, but you may be called upon to make decisions regarding the estate of the deceased.

Do not give in to pressure to make snap decisions you might regret later. Protect yourself by consulting with the appropriate advisors, such as your accountant, attorney, insurance representative or financial planner.

Important Papers

If the deceased was your spouse, or you are executor of the estate, financial advisors suggest you search for important items and documents, including:

- Insurance policies
- Employee benefit plan documents
- Business agreements
- Wills/trusts
- Income tax returns and W-2 forms
- Marriage and birth certificates

For Additional Assistance

For confidential assistance coping with grief and loss, reach a knowledgeable and understanding counselor, 24 hours a day, seven days a week at **1-800-238-1439**.

*Questions regarding your claim or claim status should be directed to 1-800-775-8805.

Access the complete Beneficiary Assistance brochure full of helpful information and advice at www.mutualofomaha.com/documents/cope-with-loss.pdf.

Group Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **Arkansas and Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** 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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

** **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES..

** **Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.