Mutual of Omaha Insurance Company
Long-Term Care Service Office
P.O. Box 64901, St. Paul, MN 55164-0901

Cognitive Questionnaire

Name of Proposed Insured _____ Date of Birth _____
Please Print

Answers to these questions may impact insurability for Long-Term Care insurance with Mutual of Omaha.

1 Do you need assistance with your medication? ☐ Yes ☐ No

2 Do you manage all of your own personal finances? ☐ Yes ☐ No

If "No," please provide details: _____

_____

3 In the past 5 years, have you been tested, by your physician, or any other insurance company for memory screening? ☐ Yes ☐ No

If "Yes," when? _____

4 In the past 5 years, have you been declined for insurance for an abnormal or failed memory study? ☐ Yes ☐ No

If "Yes," please provide details: _____

_____

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

_____ _____
Signature of Proposed Insured Date