MUTUAL OF OMAHA INSURANCE COMPANY
Long-Term Care Service Office
P.O. Box 64901, St. Paul, MN 55164-0901

NONTOBACCO QUESTIONNAIRE

Coverage ID: ______________________________

This form must be completed for each adult insured – Please attach an additional sheet of paper if necessary

Name of Proposed Insured ______________________________ Date of Birth ________________
Please Print

Address ____

Phone Number ____

1 Have you used tobacco or nicotine in any form in the past 12 months? . . . . . . ☐ Yes ☐ No

2 If you ever used tobacco, when did you quit? ______________________________

3 Within the past three years have you been treated by a health care professional for the following:

(a) Heart trouble or stroke? . . . . . . ☐ Yes ☐ No

(b) Cancer or chronic lung disease? . . . . . . ☐ Yes ☐ No

Explain any yes answers below. Include dates, diagnosis, duration, treatment and the names and address of all attending physicians.

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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.

Date ______________________________

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Signature of Insured

NOTE — You may be contacted by a local paramedical company to provide a urine specimen for nicotine testing. We sincerely appreciate your cooperation if you are contacted.