STATE CUSTOMER PRIVACY RIGHTS REQUEST FORM

For insurance customers in **AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR, VA** and **WI only**: The term "Information" means information we collect during an insurance transaction. We will not use your medical information for marketing purposes without your consent.

Your Rights to Access Your Personal Information
You have the right to request a copy of the Personal Information that we have about you. We have the right to disclose specific items of medical record information supplied by a medical care facility or medical professional, only to a licensed medical professional designated by you so that it may be properly explained. Please note we may not be able to provide information relating to investigations, claims, litigation, and other matters.

If we receive such a request, we will provide you a copy of your Personal Information within 30 days, as long as the information is reasonably locatable and retrievable.

We may charge you a nominal fee to provide you with copies of requested Personal Information.

Your Rights to Correct Your Personal Information
You have the right to correct, amend or delete Personal Information we may have recorded about you. Within thirty (30) business days from the date we receive your request, we will correct, amend, or delete the disputed information, or we will notify you that we are refusing your request and give you reasons for the refusal. If we do not accept your requested modifications, you can file a statement of disagreement and your reasons, which will become part of our file.

Should you request an amendment to your information, please understand that we will not amend personal information about you that we did not create unless we are notified of the need for amendment by the entity that created it. For example, requests to amend information in your medical records need to be directed to the medical provider or facility that created the information.

How to Exercise Your Rights
For insurance customers in **AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR, VA** and **WI**, if you wish to exercise any of the rights described above, please write to us at:

Mutual of Omaha
Attn: Privacy Office
3300 Mutual of Omaha Plaza
Omaha, NE 68175-1029

When you write to us, please provide us with your full name, complete address and your policy and/or subscriber numbers - and provided us specific details about the Personal Information you are requesting or for which you are exercising your rights described above. You may use the back of this form for that purpose.

Name: _____
Address: _____
_____
City: _____ State: _____ Zip: _____ - _____
Home Telephone Number: (____)_____
Last Four (4) Digits of Your Social Security Number: _***-**-_____
Individual Policy/Employer Group Number: _____

If this coverage is provided through an employer provide the
Subscriber Number: _____

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Your Rights to Access Your Personal Information

Please describe the Personal information you are requesting a copy of:

_____
_____
_____
_____
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_____

Your Rights to Correct Your Personal Information

1. Please select which action you are requesting – **Correct [ ], Amend [ ] Delete [ ]**

2. Please identify the Personal Information we may have recorded about you that you are requesting that Mutual of Omaha take the requested action for:

_____
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3. Please detail the reason(s) that support the requested action relating to the Personal Information in question:

_____
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I declare under penalty of perjury that the foregoing is true and correct, that I am the subject of the Personal Information for which the action requested above is related. I understand that any falsification of this statement and/or requesting or obtaining any record(s) under false pretenses is punishable under applicable laws.

_____ _____

(Signature) (Date)