Enrollment Form

Brought to you by:

Mutual of Omaha

Underwritten by: United of Omaha Life Insurance Company

Employer Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

*Employer's Name:			
Group ID:	Sub Group ID:	Location Code:	Class:
*Full-Time Employment Date:	Effective Date	Hours Worked Per Week	
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-monthly ☐ Annually		Occupation:	

Employee Section (Please print clearly. Required fields are marked with an asterisk (*).)

*Last Name		*First Name:	MI:
*Social Security Number	*Birth Date (MM/DD/YYYY):	*Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Premium Amount
Long -Term Disability	☐	☐	Paid by Employer

Voluntary Term Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Life and AD&D - Employee	☐	☐	$_____	$_____
Voluntary Life and AD&D - Spouse	☐	☐	$_____	$_____
Voluntary Life and AD&D - Child(ren)	☐	☐	$_____ (per child)	$_____ (all children)

If you are enrolling for Voluntary Term Life in excess of the Guarantee Issue Amount of $50,000 or if your spouse is enrolling for coverage in excess of 50% of the amount that you enroll for or $25,000, you must complete and submit an Evidence of Insurability form. The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/customer_service/group_plan_member/forms.html.

The following eligibility guidelines apply for dependent coverage:

- You must be age 69 or less for your dependent spouse to be eligible for coverage. Coverage terminates when you (the employee) attain the age of 70. If premium is paid for spouse coverage after you attain age 70, the premium will be refunded in accordance with the terms of the policy.
- Your dependent children must be age 19 or less (age 25 or less if a full-time student). If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy

Voluntary Short-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Short-Term Disability	☐	☐	$_____	$_____

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
				Percentage Total:	100%

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependents may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisons that follow.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF EMPLOYEE _____ **DATE** _____,_____,_____

Waiver of Group Insurance

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)), I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own expense. If waiving dental coverage, I understand that if coverage is applied for in the future, Benefit Waiting Periods may apply.

The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.