Enrollment Form

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

Short-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Short-Term Disability				
▪ Core Plan	☐	☐	$_____	Paid by Employer
▪ Buy-Up Plan	☐	☐	$_____	$_____

Voluntary Term Life and AD&D Coverage Election

Employee, Spouse and Child(ren)	Benefit Amount	Premium Amount
Voluntary Life and AD&D - Employee	☐ $10,000	$_____
	☐ $50,000	$_____
	☐ $70,000	$_____
	☐ $100,000	$_____
	☐ Other $ _____	$_____
	☐ Decline	
Voluntary Life and AD&D - Spouse	☐ $10,000	$_____
	☐ $25,000	$_____
	☐ $35,000	$_____
	☐ $50,000	$_____
	☐ Other $ _____	$_____
	☐ Decline	
Voluntary Life - Child	☐ $5,000 (per child)	$_____ (all children)
	☐ $10,000 (per child)	$_____ (all children)
	☐ Other $ _____	
	☐ Decline	

If you are enrolling for Voluntary Term Life coverage in excess of the Guarantee Issue Amount of 5 x your annual salary up to $100,000 or if your spouse is enrolling for coverage in excess of 50% of the amount that you enroll for or $50,000, 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:

- Your dependent spouse must be age 69 or less to be eligible for coverage. Coverage terminates when your spouse attains the age of 70. If any premium is paid for spouse coverage after your spouse attains age 70, the premium will be refunded in accordance with the terms of the policy.
- Your dependent children must be under age 21 (under age 25 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

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

Name of Dependent(s) Last Name	First Name	Gender Male or Female	Relationship (Spouse, Son, Daughter, etc.)	Birth Date (MM/DD/YYYY)	Social Security Number

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 (%)
					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, and that I have read and understand the benefit summaries provided to me for each line of coverage.

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.

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