Enrollment Form

Underwritten by: United of Omaha Life Insurance Company



Employer's Name: Partner Professional Staffling Location Code: Class: Full-Time Employment Date: Effective Date: Bi-Weekly Cocupation: Salary: Hourly Weekly Semi-monthy Annually First Name: Single Marital Status:	Employer Section (To be	e completed by	y the employe	r/plan administrat	or. I	Required fi	elds are m	arked with an a	sterisk (*).)	
Foll-Time Employment Date: Effective Date: Hours Worked Per Week:	*Employer's Name:	Partner Profe	ssional Staffi	ng						
Salary:	Group ID:	Sub G	roup ID:		Lo	cation Cod	e:	Cla	ss:	
Semi-monthy Semi-monthy Annually Employee Section (Plasse print clearly, Required fields are marked with an asterisk (*)) First Name Fir	*Full-Time Employment D	Date:		Effective Date:				Hours Worked	Per Week:	
Employee Section (Please print clearly, Required fields are marked with an asterisk (*))	•	•	•	•	Ос	cupation:				
First Name First Name** First Name** Gender** Marie Maried					-715		- (*))			
Short-Term Disability Coverage Election Employee Only Coverage Enroll Decline Benefit Amount Premium Amount Short-Term Disability Core Plan		se print clearly	7. Required fie	eids are marked v			((").)			MI:
Short-Term Disability Coverage Election Decline Benefit Amount Premium Amount	*Social Security Number:	[*Bi	irth Date (MM/D	D/YYYY):	*G			Marital Status:		
Short-Term Disability Core Plan Buy-Up Plan Buy-Up Plan Buy-Up Plan S S Voluntary Term Life and AD&D Coverage Election Employee, Spouse and Child(ren) Benefit Amount Premium Amount Voluntary Life and AD&D - Employee S10,000 S10,000 S10,000 S10,000 S10,000 S10,000 S10,000 S10,000 S2,000 S10,000 S2,000 S36,000 S3	Short-Term Disability C	overage Elect	ion							
** Core Plan				oll Decline		Benefit	Amount		Premium Amoun	ıt
Suy-Up Plan S S	1									
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Voluntary Life and AD&D - Employee \$10,000 \$50,000	Voluntary Term Life and	AD&D Cove	rage Election							
S50,000 S S70,000 S7	Employee, Spouse and	Child(ren)				Benefit	Amount		Premium Amou	nt
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\$35,000 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Voluntary Life and AD&D	- Spouse								_
\$50,000 \$										
Voluntary Life - Child S5,000 (per child) \$ (all children)										
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Other \$	Voluntary Life - Child				Ц		==	•	\$	
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) Gender Male or Female Male or Female (Spouse, Son, Daughter, etc.) Male Or Female							(per cr	nild)	Ф	(all children)
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) Gender Relationship Male or Female (Spouse, Son, Daughter, etc.) Male or Female (Spouse, Son, Daughter, etc.)										
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Last Name First Name Male or Female (Spouse, Son, Daughter, etc.) (MM/DD/YYYY) Social Security Number							1			
	•	` '				•			Social Securi	ty Number
Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)	Last iname FIRST is	vairie	iviale of Fema	ie (Spouse, Son	, Dau	ignier, etc.)	(IVIIV	(זוזו/טט/ו		
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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	Address of Beneficiary	Benefit		
			(MM/DD/YYYY)	(Address, City, State, Zip)	Percentage (%)		
					100%		
Secondary Beneficiary Designation							
Last Name	First Name	Relationship	Date of Birth	Address of Beneficiary	Benefit		
		to Insured	(MM/DD/YYYY)	(Address, City, State, Zip)	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.