Enrollment Form

Brought to you by:

Underwritten by: United of Omaha Life Insurance Company

Employer Section

Employer's Name: COMPASS FAMILY SERVICES			Group ID: G000AKLG
Sub Group ID:	Location Code:	Class:	Occupation:
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.)

Last Name		First Name:		MI:
Social Security Number	Birth Date (MM/DD/YYYY):	Age:	Gender: ☐ Male ☐ Female	Marital Status:

Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Premium Amount
Long -Term Disability	☐	☐	$_____

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

If a dependent is over the limiting age as specified in your plan provisions and is a full-time student, a Student Dependent Attendance Report form must be completed and submitted with this enrollment form. Please contact your employer/benefits administrator to obtain the form, or complete it online at www.mutualofomaha.com_members/sdarform.html.

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. 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 insurabiltiy 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.