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: A001 All Eligible Employees
*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
*Street Address:		E-mail Address:	
*City:	*State:		*Zip Code:

Short-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Short -Term Disability	■	☐	$_____	Paid by Employer

Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Long -Term Disability	■	☐	$_____	Paid by Employer

Basic Life and AD&D Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	■	☐	$_____	Paid by Employer

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	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Telephone Number	Benefit Percentage
						Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Telephone Number	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 guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, at my own expense. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply.

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

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Note: This fraud warning does not apply to residents of AR, CO, DC, KS, KY, LA, ME, NC, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT, and WA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)

California Fraud Warning: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

United of Omaha Life Insurance Company ■ Mutual of Omaha Plaza ■ Omaha, NE 68175

I understand that payment of premium does not ensure my eligibility for coverage.