Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

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

*Employer Name: GSPANN Technologies, Inc.		Effective Date:	Group ID:
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

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

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	E-mail Address:		
*City:	*State:	*Zip Code:	Telephone: ( ) -

Basic Life and AD&D Coverage Election

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

Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Short-Term Disability	☒	☐	_____ per Week	Paid by Employer

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Long-Term Disability	☒	☐	_____ per Month	Paid by Employer

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

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. 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)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable 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 applicable policy as well as your age and/or salary on the effective date of the coverage.

California law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable 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 summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

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

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 to state prison.

Employer Access

Guide to Submitting Member Enrollment Requests

Managing employee benefits can be time consuming. But Mutual of Omaha offers quick, convenient options that simplify plan administration.

Secure Online Plan Administration

Spend less time on paperwork and expedite transactions with our secure online portal. Through Employer Access, you can quickly and easily enroll, update or terminate employee coverage from a single screen.

Once you log in to the secure portal:

- Click on the "Members" tab and search for the member's name
- Access functions such as updating eligible employee roster, sending Evidence of Insurability (EOI), and editing or terminating employees
- Click the green "New Enrollment" button to add new employees

Employees who were terminated and rehired need to be added to the roster via a request to our service team.

Questions or Need Assistance?

Contact your Dedicated Service Team.

Not registered to use our portal?

If you are not a registered user of Employer Access, go to **mutualofomaha.com**.

1) Click on **Sign In**

2) Select **Plan Administrator**

3) Click the **Sign Up Button** *(bottom of the screen)*

See the next page for more convenient enrollment options!

Mutual of Omaha

Options When Using Paper Enrollment

Enrollment Form

If you prefer using the paper enrollment process, each employee must complete and sign an enrollment form.

Enrollment forms must be filled out completely to avoid delays in processing; required fields are marked with an asterisk (*). Return completed forms to your Dedicated Service Team.

Note: A new hire enrollment form was included in your welcome email.

Excel Spreadsheet

If you prefer to capture new employee information in a spreadsheet format, Mutual of Omaha will accept an Excel file. To expedite your request, please include the information listed here.

Type of Change Requested (Hires, Qualifying Life Event, etc.)

Effective Date of Change

- Member's First and Last Name
- Date of Birth (Employee and Spouse)
- Date of Hire or Rehire
- Signature Date (Contributory/Voluntary)
- SSN (optional but strongly preferred for Dental/Vison)
- Salary: Annual or Hourly
- Hours Worked per Week
- Coverage Elections by Product
- Tobacco Status, if Applicable
- Class (if more than one class)
- Bill Group (if receiving separate bills)
- Location Code (if receiving one bill and employees are itemized by location/department)
- Termination Date (last date worked)

Dental & Vision Benefits Require:

- Address
- Dependents: First and Last Name, Date of Birth & Gender

Important

We must receive all required information before completing the enrollment process.

Mutual of Omaha