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: Optoma Technology		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

Long-Term Disability Coverage Election

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

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life and AD&D - Employee	☐ $10,000	$_____
	☐ $30,000	$_____
	☐ $50,000	$_____
	☐ $70,000	$_____
	☐ $100,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $20,000	$_____
	☐ $25,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Child(ren)	☐ $1,000 (per child)	$_____
	☐ $10,000 (per child)	$_____
	☐ Other $_____	$_____
	☐ Decline	

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000. In no event shall your amount of insurance exceed 5 times your salary.

- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Accident Coverage Election

Important eligibility information: To be eligible for Accident insurance, you the employee and your dependent(s), if applicable, must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage.

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Voluntary Accident - Employee Only	☐	$_____
Voluntary Accident - Employee + Spouse	☐	$_____
Voluntary Accident - Employee + Child(ren)	☐	$_____
Voluntary Accident - Employee + Family	☐	$_____
	☐ Decline	

The following applies to Voluntary Accident coverage:
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Health Insurance Information for Accident Insurance Only	Employee	Spouse	Child(ren)
Does each person proposed for insurance have an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans? (Any person without such comprehensive coverage is ineligible for this insurance.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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. I understand and agree that insurance coverage for my eligible dependent(s) 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 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.

Mutual of Omaha

United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, NE 68175
mutualofomaha.com

FRAUD LANGUAGE ENDORSEMENT

This endorsement is added to your application and replaces the fraud warning with the following fraud warning below.

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