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: Trinity Management Services		Effective Date:	Group ID: G000CFQD
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: $ ☐ Hourly ☐ Monthly	☐ Weekly ☐ Semi-Monthly ☐ Bi-Weekly ☐ 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: ( ) -

Dental Coverage Election

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Dental - Employee Only	☐	$______________
Dental - Employee + Spouse or Domestic Partner	☐	$______________
Dental - Employee + Child(ren)	☐	$______________
Dental - Employee + Family	☐	$______________
	☐ Decline	

The following applies to Dental coverage:
- Your employer pays a portion of the premium for this coverage. The premium amounts above reflect your contribution.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Vision Coverage Election

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Vision - Employee Only	☐	$______________
Vision - Employee + Spouse or Domestic Partner	☐	$______________
Vision - Employee + Child(ren)	☐	$______________
Vision - Employee + Family	☐	$______________
	☐ Decline	

The following applies to Vision coverage:
- Your employer pays a portion of the premium for this coverage. The premium amounts above reflect your contribution.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If you need to list more dependents than space will allow, please include this information on a separate piece of paper and submit it with this form.

Name of Dependent		Gender	Relationship to Employee	Birth Date (MM/DD/YYYY)
Last name	First Name			

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.

** Spouse also includes the Insured Person’s state registered Domestic Partner or civil union partner as defined by state law.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

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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.