

Voluntary Term Life Insurance Enrollment Form

Underwritten by: United of Omaha Life Insurance Company



Brought to you by:



Mutual of Omaha

Employer Section (To be completed by the employer/plan administrator.)

*Employer's Name:

Group ID: **G000ABIH** District Name: District #:

Initial Enrollment following Date of Hire Late Entrant Change in Coverage Waive Coverage Other

*Full-Time Employment Date: Effective Date: Hours Worked Per Week:

*Salary: \$ Class: 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 Divorced Married Widowed

Voluntary Term Life Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Life - Employee	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Voluntary Life - Spouse	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Voluntary Life - Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____ (per child)	\$ _____ (all children)

Employee: Newly hired employees (within 31 days of hire date or 31 days of being newly eligible) are Guaranteed an Issue Amount (GIA) of \$100,000 of Voluntary Term Life Insurance (VTL). Amounts over the GIA, or after the 31 days require an Evidence of Insurability (EOI) accompany this form. Not to exceed \$500,000.

Spouse: Spouse is Guaranteed an Issue Amount (GIA) of \$25,000. Amounts over the GIA, or after the 31 days require an EOI to accompany this form. Not to exceed 50% of the employee amount.

Child(ren): Qualified children are Guaranteed an Issue Amount (GIA) of \$10,000. Choose an amount for your children from \$2,000 to \$10,000, increments of \$1,000.

The following eligibility guidelines apply for dependent coverage:

∨ Coverage terminates at age 100.

∨ Your dependent children must be under age 21 (under age 25 if a full-time student). If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy

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

Name of Dependent(s)		Gender	Relationship	Birth Date	Social Security Number
Last Name	First Name	Male or Female	(Spouse, Son, Daughter, etc.)	(MM/DD/YYYY)	

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/plan_members/sdarform.html.

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

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
Percentage Total:					100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	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 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. I understand and agree that life insurance coverage for my eligible dependents 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 decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

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.

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 insurability may be required, acceptable to the Insurance Company, at my own

Personnel Office Use Only

Employee Verification: Has the employee been actively at work for the past 90 days? Y / N

Job Title: Salary: Effective Date: Date of Hire: Payment Collected 10thly 12thly

Employer _____ Signed by Employer _____