Enrollment Form

Brought to you by: Mutual of Omaha

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: Madison County		*Effective Date:	Group ID: G000AMEV
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(*).) **Enrollment ID: 6095**

*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:	Telephone:

Voluntary Life and AD&D Coverage Election

If you (the employee) are age 70 or older: The guaranteed amount available to you and your spouse without answering health questions (Guarantee Issue Amount) and the life insurance benefit amount elected are subject to benefit reductions due to your age. At age 70, the guaranteed amount and the benefit elected decrease to 65% of the original amount. At age 75, amounts decrease to 45%. At age 80, amounts decrease to 30%. At age 85, amounts decrease to 20%. At age 90, amounts decrease to 15%. As your life insurance benefit amount decreases, your premium amount will also decrease. If applicable, reduced benefit amounts may be shown below.

Employee and Dependent Coverage	Benefit Amount - Select One Option	Bi-Weekly Premium Amount (Per Paycheck = 26/Year)
Voluntary Life and AD&D - Employee	☐ $20,000	$_____
	☐ $50,000	$_____
	☐ $70,000	$_____
	☐ $100,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Spouse*	☐ $10,000	$_____
	☐ $15,000	$_____
	☐ $20,000	$_____
	☐ $25,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life and AD&D - Child(ren)**	☐ $10,000 (per child)	$.92 (all children)
	☐ Other $_____	$_____
	☐ Decline	

If you are enrolling for Voluntary Term Life coverage in excess of the Guarantee Issue Amount of 5 times your annual salary or $100,000 (whichever is less), or if your spouse is enrolling for coverage in excess of $25,000, you must complete and submit an Evidence of Insurability form. The form is available from your employer, or complete online at www.mutualofomaha.com/eoi.

The following eligibility guidelines apply for dependent coverage:

*You must be age 69 or less for your dependent spouse to be eligible for coverage. Spouse coverage terminates when you (the employee) attain the age of 70. If any premium is paid for spouse coverage after you attain age 70, the premium will be refunded in accordance with the terms of the policy.

**Your dependent child(ren) 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.

Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck = 26/Year)
Short-Term Disability	☑	☐	$_____	Paid by Employer

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck = 26/Year)
Long-Term Disability	☑	☐	$_____	Paid by Employer

Basic Life and AD&D Coverage Elections

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck = 26/Year)
Basic Life and AD&D - Employee	☑	☐	$_____	Paid by Employer
Basic Life and AD&D - Spouse*	☐	☐	$_____	Paid by Employer
Basic Life and AD&D - Child(ren)**	☐	☐	$_____	

**The Child(ren) Benefit Amount listed applies to children age six months to the limiting age of the plan only. A different benefit amount may apply to any child(ren) while they are under the age of six months. Please contact your employer/benefits administrator for additional information.

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

If more than one beneficiary is named, the beneficiaries shall share benefits 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. If you need to designate more beneficiaries than space will allow, please include this information on a separate piece of paper and submit it with this form, clearly stating your name.

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, active employment and/or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that life 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 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.

 NAME:_____