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: **Tooele City**		*Effective Date:	Group ID:
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary:	*Date of Hire:	Hours Worked Per Week:	

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:	*Marital Status:

Voluntary Life Coverage Election

Employee and Dependent Coverage	Benefit Amount – Select One Option***	Bi-Weekly Premium Amount (Per Paycheck)
Voluntary Life - Employee	☐ $20,000 ☐ $50,000 ☐ $70,000 ☐ $100,000 ☐ Other $_____ ☐ Decline (Evidence of Insurability will be required in the future once you have declined this benefit.)	$_____ $_____ $_____ $_____ $_____
Voluntary Life - Spouse*	☐ $10,000 ☐ $25,000 ☐ $35,000 ☐ $50,000 ☐ Other $_____ ☐ Decline (Evidence of Insurability will be required in the future once you have declined this benefit.)	$_____ $_____ $_____ $_____ $_____
Voluntary Life - Child(ren)**	☐ $10,000 (per child) ☐ Other $_____ (per child) ☐ Decline (Evidence of Insurability will be required in the future once you have declined this benefit.)	$0.51 (all children) $_____ (all children)

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 $50,000 , you must complete and submit an Evidence of Insurability form. The form is available from your employer, or is available online at http://www.mutualofomaha.com/customer_service/group_plan_member/forms.html.
The following eligibility guidelines apply for dependent coverage:
*Your dependent spouse must be age 69 or less to be eligible for coverage. Coverage terminates when your spouse attains the age of 70. If any premium is paid for spouse coverage after your spouse attains age 70, the premium will be refunded in accordance with the terms of the policy.
**Your dependent child(ren) must be under age 26 (under age 26 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.
***Dependents cannot enroll for coverage in excess of 50% of amount elected by you (the employee).

Voluntary AD&D Coverage Election (Special Risk)

Employee and Dependent Coverage	Select One Coverage Option	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck)
Voluntary AD&D - Employee	☐	$_____	$_____
Voluntary AD&D – Employee & Family	☐	$_____	$_____
Voluntary AD&D - Decline	☐		

Short-term Disability Election

STD - Contributory	☐ Yes & I authorize payroll withholding of my share of the premium. ☐ No, I have declined coverage. (Evidence of Insurability will be required in the future once you have declined this benefit.)

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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, clearly stating your name.

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

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.)

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 benefit and premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the benefit plan as well as your salary and age on the effective date of the plan.

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 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 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, I understand that evidence of insurability will be required, acceptable to the insurance company, **at my own expense**.

The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.