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:

Basic Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and Basic AD&D - Employee	☒	☐	$_____	Paid by Employer
Basic Life - Spouse	☐	☐	$5,000	Paid by Employer
Basic Life - Child(ren)	☐	☐	$2,500/child	Paid by Employer

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.)	$0.55 (all children) $_____ (all children)

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, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $1000,000. For your spouse, the GIA is the lesser of 50% of the amount you enroll for, or $50,000. In no event shall your amount of insurance exceed 5 times your salary.

The following eligibility guidelines apply for dependent coverage:

- 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 50% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 50% of your elected benefit amount.
- Your dependent spouse must be age 69 or less to be eligible for Voluntary Life 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. 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.

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.)

FORM CONTINUES ON PAGE 2

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

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 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 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 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** _____/_____/_____

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.

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. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)