

# Enrollment Form

Brought to you by:



Mutual of Omaha

Underwritten by:

Mutual of Omaha Insurance Company  
Companion Life Insurance Company

Employer Section					
Employer's Name:					
City:		State:		Zip Code:	
Sub Group Name:			Location Code:		
Group I.D.:	Sub-group I.D.:	Class:	Effective Date:	Hours worked per week:	
Salary:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Biweekly	Full-Time Employment Date:	Occupation:
\$	<input type="checkbox"/> Monthly	<input type="checkbox"/> Semimonthly	<input type="checkbox"/> Annually		

Employee Section (Please Print)					
Social Security:			Full Name:		
Birth Date:	Age:	Gender: (Male or Female)		Marital Status:	
Street Address:					
City:		State:		Zip Code:	

Coverage Election						Review & Check as Applicable			
		Yes	No			Yes	No		
Life/AD&D	Employee	<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability	Employee	<input type="checkbox"/>	<input type="checkbox"/>		

Voluntary Life Coverage Election						Review & Check As Applicable			
		Yes	No	N/A	Benefit Amount	Premium Amount			
Voluntary Life	Employee	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> \$10,000	\$ _____			
					<input type="checkbox"/> \$50,000	\$ _____			
					<input type="checkbox"/> \$100,000	\$ _____			
					<input type="checkbox"/> \$150,000	\$ _____			
					<input type="checkbox"/> \$ _____ (other)	\$ _____			
Voluntary Life	Spouse	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> \$ 5,000	\$ _____			
					<input type="checkbox"/> \$10,000	\$ _____			
					<input type="checkbox"/> \$15,000	\$ _____			
					<input type="checkbox"/> \$20,000	\$ _____			
					<input type="checkbox"/> \$25,000	\$ _____			
Voluntary Life	Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> \$ _____ (each child)	_____ (each child)			

Dependent Information (Please Print)				
Name of Dependent(s)	Gender	Relationship	Birth Date	Social Security Number
Spouse:			Mo. Day Yr.	
Child(ren):				

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured							
(If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)							
Primary Beneficiary				Secondary Beneficiary			
Last Name	First	M.I.	Relationship to Insured	Last Name	First	M.I.	Relationship to Insured
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

**Instructions:** Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, for **MUST** be signed and dated to authorize payroll deductions. **Should you decline coverage(s) for either yourself or your eligible dependent(s), you MUST complete the Waiver of Group Insurance that follows.**

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

**SIGNATURE OF APPLICANT** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Applicable to Life Plans**

*For residents of New York:*

- Your employer may include a Living Care (Accelerated Death Benefit) in your plan.
- If so, there is no additional premium charge associated with the Living Care benefit.
- Receipt of Living Care (Accelerated Death Benefit) may affect eligibility for public assistance programs and may be taxable.

**Waiver of Group Insurance (Should you decline coverage(s) for either yourself or your eligible dependent(s), you MUST complete and sign this section.)**

I have been given the opportunity to enroll for Group Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll in the following coverage(s):

Voluntary Life

For:  Myself (and all eligible dependents, if applicable)  My eligible spouse only  
 My eligible dependent spouse and children only  My eligible dependent children only

Reason:  Cannot afford  Other Reason \_\_\_\_\_

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s), I understand that my dependent(s) and I may be considered a late enrollee(s) and must submit evidence of insurability at my own expense.

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

I understand and accept the Waiver of Group Insurance provisions.

**SIGNATURE OF EMPLOYEE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

Insurance Company Use Only: Acknowledgement \_\_\_\_\_ Date Recorded \_\_\_\_/\_\_\_\_/\_\_\_\_