



Mutual of Omaha

POLICYHOLDER ADMINISTRATION WORKSHEET

Thank you for choosing Mutual of Omaha as the carrier for your client. This form contains valuable information needed to issue the group correctly. We ask that you complete this form with your client or ask your client to complete the form. Our Group Office team prides itself on providing a smooth transition, as long as we have all the information we need.

To meet our commitment to you, we ask that you return the following original items / information listed below to the Mutual of Omaha, Long Island Group Office no later than _____.

- Original Signed Application**
- Copy of Final Proposal illustrating sold plan(s) and sold rate(s)**
- Binder Premium Check** (for the first month's premium)
- Enrollment Cards**

Contributory and Voluntary plans

We require the submission of enrollment and waiver forms during the initial enrollment. Waiver forms are only required for the initial enrollment. A copy of all forms **must** be retained by the **employer**.

Non Contributory plans

We require the submission of an updated census for the initial enrollment, with the exception of dental. Dental enrollment requires the submission of enrollment forms. The **employer must** maintain a copy of each enrollment form to be submitted in the event of a Life claim. Enrollment forms are required to enroll new employees for list billed groups.

- Final Census**

We **require** a final census with the following information for each employee (**if list billed**):

Full Name

Social Security Number

Gender

Date of Birth

Class Number (for multi-class plans)

Occupation (for Short Term Disability and Long Term Disability)

Salary (required for any benefit that is not a flat amount)

Salary Mode (reflects how the salary is represented on the census i.e. \$10.50 is hourly, \$78,000 is annually)

Department Number (if department billing is requested)

Date of Hire

Dependent Information (required for dental and voluntary life – name, dob and social security number)

COBRA – (indicated on census)

If Grandfathering, indicate prior carrier benefit amount as applicable

- Prior Carrier Booklet for Each Line of Coverage**
- Prior Carrier Billing For Each Line of Coverage** (also for Self-Administered groups)
- Completed POLICYHOLDER ADMINISTRATION WORKSHEET**

For Questions regarding implementation contact:

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Melville, NY 11747
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POLICYHOLDER ADMINISTRATION WORKSHEET

Policyholder Information

Legal Name of Group: _____ (Must match application)

***Please Note:** Is the legal name in **Upper & Lower case** or **ALL CAPS**?
Is **punctuation** used in the legal name?

Employer Identification Number (EIN, assigned by the IRS): _____

Physical Address: Street _____
City _____ State _____ Zip _____

Mailing Address (if different): Street _____
City _____ State _____ Zip _____

Phone number: _____ **Fax number:** _____

Contact Information

General: Name _____ Phone _____ Ext _____
Title _____ Email _____

Billing: Name _____ Phone _____ Ext _____
Title _____ Email _____

Claims: Name _____ Phone _____ Ext _____
Title _____ Email _____

Policy Information

What plans were purchased?

- | | | | | | |
|-----------------|--------------------------|---------|--------------------------|---------|--------------------------|
| Life w/AD&D | <input type="checkbox"/> | STD | <input type="checkbox"/> | LTD | <input type="checkbox"/> |
| Vol Life w AD&D | <input type="checkbox"/> | Vol STD | <input type="checkbox"/> | Vol LTD | <input type="checkbox"/> |
| w/spouse | <input type="checkbox"/> | | | | |
| w/child | <input type="checkbox"/> | | | | |

Effective Date: _____

Employer contribution percent:

Life/AD&D _____ % STD _____ % LTD _____ % Dependent _____ %

Sold Rates:

Life _____ AD&D _____ STD _____ LTD _____

Will prior carrier benefit amounts be Grandfathered: yes no

If yes, prior carrier benefits amount must be included on the final census.

Active Employee Eligibility

Total number of benefit eligible employees: _____

Does the final census include: **ALL** employees even if they are **still in the waiting period**, if applicable
 ONLY employees who **have already met the waiting period**, if applicable)

Required number of work hours per week: _____

Dependent Eligibility (if applicable): **To age 19** **To age _____, if a full time student**

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Active Employee Eligibility continued

Waiting period for current employees: None
 Days _____ Months _____

NOTE: If **NONE** is selected for current employees, **All** employees actively at work on the policy effective date will be eligible regardless of how long they have been employed.

If a **waiting period** is selected for current employees, **only** those employees actively at work on the policy effective date who have **already met** the waiting period, will be eligible.

Waiting period for future employees: None
 Days _____ Months _____

Coverage is Effective: **On the day** following completion of the waiting period (Not available for DentaBenefits)
 On the 1st day of the month following completion of the waiting period

Coverage Ends: **On the day** of termination (required for STD and LTD)
 On the last day of the month following termination

Earnings Definition Includes: Commissions Bonuses Overtime Shift Differential Pay None of these

Retiree Eligibility (if applicable)

Total number of **benefit eligible** retirees: _____ Total number of **participating** retirees: _____

Minimum retirement age: _____ Minimum number of years of service: _____

Is retiree coverage provided indefinitely: yes no

If no, when will coverage end: _____

Printed Materials

Do any employees **live or work** in any of the states listed? If so, indicated how many are in each state?

AZ____ CA____ KS____ FL____ HI____ ID____ IN____ MD____ MT____ SC____ SD____ WA____ TX____ MN____

ERISA Information:

Plan Number (assigned by Plan Sponsor): _____ (plan numbers are 3 digit numbers starting with a 5)

Plan Year (month and day) _____ (typically the policy anniversary date)

We strongly recommend that ERISA information be included in the certificate booklets as it contains claim filing rights and other required employee notification information. **If you do not have an assigned ERISA Plan number/Plan year, we will use 510 and the policy anniversary date.** For groups over 100 lives, we will prepare the Form 5500 Schedule A information based on the Plan year provided above.

Electronic booklets are prepared automatically.

Prepare Drafts: yes no (Automatically prepared for groups over 200 lives)

Mail booklets to: Policyholder Broker/Consultant Other _____

Prior Carrier

Name: _____ Years with Carrier: _____

Address: _____

Policy Number/s and type of coverage/s: _____

If coverage was provided by more than one carrier, please provide the above information for each carrier on a separate page.

****We require a current copy of the prior carrier's booklet prior to releasing a policy number.****

