

Enrollment Form

United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175



Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)				
*Employer Name: City of Villa Rica		Effective Date:		Group ID: G000AZBC
Sub Group ID:	Location Code:	Class:		Occupation:
*Salary:	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Annually	*Date of Hire:		Hours Worked Per Week:
Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)				
*Last Name:		*First Name:		MI:
*SSN/ID Number:		*Birth Date (MM/DD/YYYY):		*Gender:
*Marital Status:				
*Street Address:				
*City:		*State:		*Zip Code:
Tobacco Use Section (If you do not complete this section, tobacco premiums will apply. Required fields are marked with an asterisk(*).)				
The response to the following questions will determine the premium amount that applies to one or more of the coverages offered below.				
			Employee	Spouse
*In the last 12 months, have you smoked a cigarette, cigar or pipe; chewed tobacco; or used tobacco or nicotine in any other form (including forms of nicotine replacement)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Basic Life Coverage Election				
Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life - Employee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____	Paid by Employer
Voluntary Critical Illness/Specified Disease Coverage Election				
Health Insurance Information for Critical Illness and Accident Insurance Only				
			Employee	Spouse
			Child(ren)	
*For Residents of CA Only: Does each person proposed for insurance have an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans? (Any person without such comprehensive coverage is ineligible for this insurance.)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee and Dependent Coverage	Benefit Amount - Select One Option			Premium Amount
Voluntary Critical Illness/Specified Disease - Employee	<input type="checkbox"/> \$10,000			\$ _____
	<input type="checkbox"/> Other \$ _____			\$ _____
	<input type="checkbox"/> Decline			
Voluntary Critical Illness/Specified Disease - Spouse	<input type="checkbox"/> \$5,000			\$ _____
	<input type="checkbox"/> \$10,000			\$ _____
	<input type="checkbox"/> Other \$ _____			\$ _____
	<input type="checkbox"/> Decline			
The following applies to Voluntary Critical Illness/Specified Disease coverage:				
- You must elect coverage for yourself for your dependent(s) to be eligible.				
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.				
- Child(ren) are automatically enrolled for 25% of your elected benefit amount, for no additional charge.				
- Your dependent child(ren) must be under age 26 to be eligible for insurance.				
Voluntary Short-Term Disability Coverage Election				
Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Short-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____ per Week	\$ _____
Long-Term Disability Coverage				
Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Long-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____ per Month	PAID BY EMPLOYER

Voluntary Accident Coverage Election

Important eligibility information: To be eligible for Accident insurance, you the employee and your dependent(s), if applicable, must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage.

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Voluntary Accident - Employee Only	<input type="checkbox"/>	\$ <u>7.23</u>
Voluntary Accident - Employee + Spouse	<input type="checkbox"/>	\$ <u>10.25</u>
Voluntary Accident - Employee + Child(ren)	<input type="checkbox"/>	\$ <u>11.75</u>
Voluntary Accident - Employee + Family	<input type="checkbox"/>	\$ <u>15.64</u>
	<input type="checkbox"/> Decline	

The following applies to Voluntary Accident coverage:
 - Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Bi-Weekly Premium Amount
Voluntary Life and AD&D - Employee	<input type="checkbox"/> Retain Current Amount	\$ _____
	<input type="checkbox"/> \$10,000	\$ _____
	<input type="checkbox"/> \$50,000	\$ _____
	<input type="checkbox"/> \$100,000	\$ _____
	<input type="checkbox"/> Other \$ _____	\$ _____
	<input type="checkbox"/> Decline	
Voluntary Life and AD&D - Spouse	<input type="checkbox"/> Retain Current Amount	\$ _____
	<input type="checkbox"/> \$5,000	\$ _____
	<input type="checkbox"/> \$10,000	\$ _____
	<input type="checkbox"/> \$30,000	\$ _____
	<input type="checkbox"/> Other \$ _____	\$ _____
	<input type="checkbox"/> Decline	
Voluntary Life and AD&D - Child(ren)	<input type="checkbox"/> \$10,000 (per child)	\$1.00 (all children)
	<input type="checkbox"/> Decline	

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/benefits administrator, or is available online at <http://www.mutualofomaha.com/eoi>. The GIA is the lesser of 5 times your annual salary, or \$150,000. For your spouse, the GIA is the lesser of 50% of the amount you enroll for, or \$30,000. In no event shall your amount of insurance exceed 5 times your salary.

- 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.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Dental Coverage Election

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Voluntary Dental - Employee Only	<input type="checkbox"/>	\$ 1.61
Voluntary Dental - Employee + Spouse	<input type="checkbox"/>	\$ 5.59
Voluntary Dental - Employee + Child(ren)	<input type="checkbox"/>	\$ 7.22
Voluntary Dental - Employee + Family	<input type="checkbox"/>	\$ 11.42
<input type="checkbox"/> Decline		

The following applies to Voluntary Dental coverage:
 - Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Vision Coverage Election

Employee and Dependent Coverage	Select One Coverage Option	Premium Amount
Voluntary Vision - Employee Only	<input type="checkbox"/>	\$ 0.35
Voluntary Vision - Employee + Spouse	<input type="checkbox"/>	\$ 0.90
Voluntary Vision - Employee + Child(ren)	<input type="checkbox"/>	\$ 0.97
Voluntary Vision - Employee + Family	<input type="checkbox"/>	\$ 1.73
<input type="checkbox"/> Decline		

The following applies to Voluntary Vision coverage:
 - Your dependent child(ren) must be under age 26 to be eligible for insurance.

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If naming more than one dependent, please attach a separate signed and dated sheet.

Dependent Name					
Last Name	First Name	Gender	Relationship	Date of Birth	SSN

Please continue to back page

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

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable 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 applicable policy as well as your age and/or salary on the effective date of the coverage.

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 _____ / _____ / _____

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.)

Ohio Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.