Enrollment Form
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Mutual of Omaha

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Stoughton Hospital Association		Effective Date:	Group ID: G000ANA1
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ 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:	

Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Semi-Monthly Premium Amount (Per Paycheck - 24/Year)
Short-Term Disability	☒	☐	66 2/3% up to $1,500	Paid by Employer

Employee Basic Life and AD&D Coverage Election and Dependent Life Elections

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Semi-Monthly Premium Amount (Per Paycheck - 24/Year)
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer
Dependent Life - Spouse	☐	☐	_____	Employee Paid
Dependent Life - Child(ren)	☐	☐	_____	Employee Paid

The following applies to dependent Life coverage:
- The premium amount for spouse and child(ren)is blended – the same premium amount applies whether spouse coverage, child(ren) coverage, or both is/are selected.
- The Child(ren) Benefit Amount listed applies to any child age six months or older. A different benefit amount may apply to any child under the age of six months. Please contact your employer/benefits administrator for additional information.
- Your dependent child(ren) must be under age 21, or under age 25 if a full-time student, to be eligible for insurance.

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Semi-Monthly Premium Amount (Per Paycheck - 24/Year)
Voluntary Long-Term Disability	☐	☐	66 2/3% up to $10,000	$_____

Voluntary Life Coverage Election

Employee Coverage Only	Benefit Amount - Select One Option	Semi-Monthly Premium Amount (Per Paycheck - 24/Year)
Voluntary Life - Employee	☐ $10,000	$_____
	☐ $50,000	$_____
	☐ $100,000	$_____
	☐ $150,000	$_____
	☐ Other $_____	$_____
	☐ Decline	

You must complete and submit an Evidence of Insurability form if you 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. In no event shall your amount of insurance exceed 5 times your salary.

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.)*