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: **The Summit Health & Rehab**		*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 Coverage Only	**Enroll**	**Decline**	**Benefit Amount**	**Semi-Monthly Premium Amount (Per Paycheck)**
Basic Life and AD&D - Employee	☑	☐	$_____	Paid by Employer

Voluntary Short-Term Disability Coverage Election

Employee Coverage Only	**Currently Enrolled?**	**Enroll**	**Decline**	**Benefit Amount–**	**Semi-Monthly Premium Amount (Per Paycheck)**
Voluntary Short-Term Disability	N/A	☐	☐	$_____ per Week	$_____

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	**Currently Enrolled?**	**Enroll**	**Decline**	**Benefit Amount**	**Semi-Monthly Premium Amount (Per Paycheck)**
Voluntary Long-Term Disability	N/A	☐	☐	$_____ per Month	$_____

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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 ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment 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 decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Waiver of Group Insurance

Should I apply for waived coverage(s) in the future, I understand that evidence of insurability may 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.