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: Lincoln County		Effective Date:	Group ID: G000BQTF
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:	

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)?	☐ Yes ☐ No	☐ Yes ☐ No

Voluntary Life Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Bi-Weekly Premium Amount (24/Year)
Voluntary Life - Employee	☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life - Spouse	☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life - Child(ren)	☐ $10,000 (per child) ☐ Other $_____ ☐ Decline	$0.65 (all children) $_____

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 $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000. 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 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 85 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 85.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (24/Year)
Voluntary Long-Term Disability	☐	☐	_____ per Month	$_____

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.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee and Dependent Coverage	Benefit Amount - Select One Option	Bi-Weekly Premium Amount (24/Year)
Voluntary Critical Illness/Specified Disease - Employee	☐ $5,000 ☐ $15,000 ☐ $25,000 ☐ $30,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Critical Illness/Specified Disease - Spouse	☐ $5,000 ☐ $30,000 ☐ Other $_____ ☐ 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.

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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	Bi-Weekly Premium Amount (24/Year)
Voluntary Accident - Employee Only	☐	$7.50
Voluntary Accident - Employee + Spouse	☐	$11.50
Voluntary Accident - Employee + Child(ren)	☐	$14.00
Voluntary Accident - Employee + Family	☐	$19.00
	☐ Decline	

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

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.)*

Employer Access

Guide to Submitting Member Enrollment Requests

Managing employee benefits can be time consuming. But Mutual of Omaha offers quick, convenient options that simplify plan administration.

Secure Online Plan Administration

Spend less time on paperwork and expedite transactions with our secure online portal. Through Employer Access, you can quickly and easily enroll, update or terminate employee coverage from a single screen.

Once you log in to the secure portal:

- Click on the "Members" tab and search for the member's name
- Access functions such as updating eligible employee roster, sending Evidence of Insurability (EOI), and editing or terminating employees
- Click the green "New Enrollment" button to add new employees

Employees who were terminated and rehired need to be added to the roster via a request to our service team.

Questions or Need Assistance?

Contact your Dedicated Service Team.

Not registered to use our portal?

If you are not a registered user of Employer Access, go to **mutualofomaha.com**.

1) Click on **Sign In**

2) Select **Plan Administrator**

3) Click the **Sign Up Button** *(bottom of the screen)*

See the next page for more convenient enrollment options!

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Options When Using Paper Enrollment

Enrollment Form

If you prefer using the paper enrollment process, each employee must complete and sign an enrollment form.

Enrollment forms must be filled out completely to avoid delays in processing; required fields are marked with an asterisk (*). Return completed forms to your Dedicated Service Team.

Note: A new hire enrollment form was included in your welcome email.

Excel Spreadsheet

If you prefer to capture new employee information in a spreadsheet format, Mutual of Omaha will accept an Excel file. To expedite your request, please include the information listed here.

Type of Change Requested (Hires, Qualifying Life Event, etc.)

Effective Date of Change

- Member's First and Last Name
- Date of Birth (Employee and Spouse)
- Date of Hire or Rehire
- Signature Date (Contributory/Voluntary)
- SSN (optional but strongly preferred for Dental/Vison)
- Salary: Annual or Hourly
- Hours Worked per Week
- Coverage Elections by Product
- Tobacco Status, if Applicable
- Class (if more than one class)
- Bill Group (if receiving separate bills)
- Location Code (if receiving one bill and employees are itemized by location/department)
- Termination Date (last date worked)

Dental & Vision Benefits Require:

- Address
- Dependents: First and Last Name, Date of Birth & Gender

Important

We must receive all required information before completing the enrollment process.

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