Enrollment Form

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: **Sumter County Board of Education**			
Group ID: **G000APV1**	Sub Group ID:	Location Code:	Class:
*Full-Time Employment Date:	Effective Date:	Hours Worked Per Week:	
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-monthly ☐ Annually	Occupation:		

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: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
*Street Address:	E-mail 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.

*Have you (the employee/member) used tobacco in any form (ex. Cigarettes or chewing tobacco) within the past 12 months? ☐ Yes ☐ No

*Has your spouse used tobacco in any form (ex. Cigarettes or chewing tobacco) within the past 12 months? ☐ Yes ☐ No ☐ N/A

Voluntary Short-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Short-Term Disability	☐	☐	$_____	$_____

Voluntary Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Long-Term Disability	☐	☐	$_____	$_____

Voluntary Critical Illness/Specified Disease Coverage Election

Important eligibility information: To be eligible for Critical Illness/Specified Disease insurance, you (the employee/member) 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.

	Benefit Amount	Premium Amount
Voluntary Critical Illness/Specified Disease - Employee/Member	☐ $_____ ☐ Decline	$_____

Voluntary Term Life and AD&D Coverage Election

Employee, Spouse and Child(ren)		Benefit Amount	Premium Amount
Voluntary Life and AD&D - Employee	☐	$20,000	$_____
	☐	$100,000	$_____
	☐	$150,000	$_____
	☐	$200,000	$_____
	☐	Other $ _____	$_____
	☐	Decline	
Voluntary Life and AD&D - Spouse	☐	$10,000	$_____
	☐	$25,000	$_____
	☐	$50,000	$_____
	☐	Other $ _____	$_____
	☐	Decline	
Voluntary Life - Child	☐	$10,000 (per child)	$_____
	☐	Other $ _____	
	☐	Decline	

If you are enrolling for Voluntary Term Life coverage in excess of the Guarantee Issue Amount of 7 x your annual salary up to $200,000 or if your spouse is enrolling for coverage in excess of $50,000, you must complete and submit an Evidence of Insurability form. The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi.

- Your dependent children must be under age 21 (under age 25 if a full-time student). If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy
- You must enroll for VTL coverage for yourself in order for your dependent(s) to be eligible for VTL coverage

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

If more than one beneficiary is named, the beneficiaries shall share benefit 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.

Primary Beneficiary Designation

Last Name	First Name	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Telephone Number	Benefit Percentage (%)
						Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	SSN/ID Number	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Telephone Number	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 premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

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 and agree that insurance coverage for my eligible dependents 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 insurance company, at my own expense. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the 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 summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the 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.)