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: Source Logistics, Inc.		Effective Date:	Group ID: G000AQHZ
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week: 40+

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	Monthly Premium Amount (Per Paycheck - 12/Year)
Short-Term Disability	☒	☐	Up to $500.00 per Week	Paid by Employer

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (Per Paycheck - 12/Year)
Long-Term Disability	☒	☐	Up to 66 % Base per Month	Paid by Employer

Basic Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Monthly Premium Amount (Per Paycheck - 12/Year)
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer
Basic Life - Spouse	☐	☐	$2,000.00	Paid by Employer
Basic Life - Child(ren)	☐	☐	$1,000.00	Paid by Employer

The following applies to dependent Basic 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 19, or under age 25 if a full-time student, 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.)*

Arkansas 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.

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. Information is not required but will help ensure your beneficiary receives payment.

Primary Beneficiary Designation

#	Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN	Benefit Percentage (%)
1						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
2						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
3						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
					Percentage Total:	100%

Secondary Beneficiary Designation

#	Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN	Benefit Percentage (%)
1						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
2						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
3						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
					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 that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work, active employment and/or active eligibility requirements that pertain to the policy to be eligible for coverage. 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.

United of Omaha Insurance Company ◘Mutual of Omaha Plaza ◘Omaha, NE 68175