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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: City of Albuquerque		Effective Date: ~~07/01/2019~~	Group ID:
Sub Group ID:Sandoval County	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
*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

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	VTL Benefit Amount - Select One Option	Bi-Weekly Premium Amount (Per Paycheck - 26/Year) VTL Rate	
Voluntary Life - Employee	☐ $40,000	$________	
	☐ $150,000	$________	
	☐ $220,000	$________	
	☐ $350,000	$________	
	☐ Other $_______	$________	
	☐ Decline		
Voluntary Life - Spouse	☐ $10,000	$________	
	☐ $20,000	$________	
	☐ $30,000	$________	
	☐ $50,000	$________	
	☐ Other $_______	$________	
	☐ Decline		
Voluntary Life - Child(ren)	☐ $10,000 (per child)		$0.96 (all children)
	☐ Decline		

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 7 times your annual salary, or $350,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $50,000. In no event shall your amount of insurance exceed 7 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 100 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 100.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

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Voluntary Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck - 26/Year)
	☐	☐	60% up to $1,155	$_____________

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only-Your employer pays 70% of the premium for this coverage.	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck - 26/Year)
	☐	☐	60% up to $5,000	$_____________

Basic Life and AD&D Coverage Election

Employee Coverage Only-Your employer pays 70% of the premium for this coverage.	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (Per Paycheck - 26/Year)
	☐	☐	1.4X Annual Salary up to $50,000	$_____________

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.)*

New Mexico Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.