# 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: Cascade Designs, Inc. | | Effective Date: | Group ID: G000BYWT |
| Sub Group ID: | Location Code: | Class: | Occupation: |
| *Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly<br>$ ☐ 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: | |

**Voluntary Life and AD&D Coverage Election**

| Employee and Dependent Coverage | VTL Benefit Amount - Select One Option | Monthly Premium Amount (12/Year) VTL Rate | AD&D Benefit Amount - Select One Option | Monthly Premium Amount (12/Year) AD&D Rate |
|---|---|---|---|---|
| Voluntary Life and AD&D - Employee | ☐ Retain Current Amount | $_____ | ☐ Retain Current Amount | $_____ |
| - Current VTL Benefit Amount: _____ | ☐ $10,000 | $_____ | ☐ $10,000 | $_____ |
| - Current AD&D Benefit Amount: _____ | ☐ $30,000 | $_____ | ☐ $30,000 | $_____ |
| | ☐ $50,000 | $_____ | ☐ $50,000 | $_____ |
| | ☐ $130,000 | $_____ | ☐ $130,000 | $_____ |
| | ☐ $200,000 | $_____ | ☐ $200,000 | $_____ |
| | ☐ Other $_____ | $_____ | ☐ Other $_____ | $_____ |
| | ☐ Decline | | | |
| Voluntary Life and AD&D - Spouse | ☐ Retain Current Amount | $_____ | ☐ Retain Current Amount | $_____ |
| - Current VTL Benefit Amount: _____ | ☐ $5,000 | $_____ | ☐ $5,000 | $_____ |
| - Current AD&D Benefit Amount: _____ | ☐ $15,000 | $_____ | ☐ $15,000 | $_____ |
| | ☐ $25,000 | $_____ | ☐ $25,000 | $_____ |
| | ☐ $30,000 | $_____ | ☐ $30,000 | $_____ |
| | ☐ Other $_____ | $_____ | ☐ Other $_____ | $_____ |
| | ☐ Decline | | | |
| Voluntary Life and AD&D - Child(ren) | ☐ Retain Current Amount | $_____ | ☐ Retain Current Amount | $_____ |
| - Current VTL Benefit Amount: _____ | ☐ $10,000 (per child) | $0.70 (all children) | ☐ $10,000 (per child) | $0.10 (all children) |
| - Current AD&D Benefit Amount: _____ | ☐ Other $_____ | $_____ | ☐ Other $_____ | $_____ |
| | ☐ 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 $200,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $30,000. 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.
- Your dependent spouse must be age 85 or less for your spouse to be eligible for coverage. Coverage terminates when your spouse reaches the age of 85.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

## Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If you need to list more dependents than space will allow, please include this information on a separate piece of paper and submit it with this form.

| Name of Dependent | | Gender | Relationship to Employee | Birth Date (MM/DD/YYYY) |
|---|---|---|---|---|
| **Last name** | **First Name** | | | |
| | | | | |
| | | | | |
| | | | | |

## 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.)*

**Washington Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.