# 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: Cross Church | | Effective Date: | Group ID: G000AMW8 |
| 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 | Benefit Amount - Select One Option | Premium Amount |
|---|---|---|
| Voluntary Life and AD&D - Employee | ☐ $20,000<br>☐ $50,000<br>☐ $80,000<br>☐ $100,000<br>☐ Other $_____<br>☐ Decline | $_____<br>$_____<br>$_____<br>$_____<br>$_____ |
| Voluntary Life and AD&D - Spouse | ☐ $10,000<br>☐ $20,000<br>☐ $25,000<br>☐ Other $_____<br>☐ Decline | $_____<br>$_____<br>$_____<br>$_____ |
| Voluntary Life and AD&D - Child(ren) | ☐ $5,000 (per child)<br>☐ $10,000 (per child)<br>☐ Other $_____<br>☐ Decline | $_____<br>$_____<br>$_____ |

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 50% 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 50% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 50% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 21, or under age 25 if a full-time student, to be eligible for insurance.

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

| Employee Coverage Only | Enroll | Decline | Benefit Amount | Premium Amount |
|---|---|---|---|---|
| Basic Life and AD&D - Employee | ☒ | ☐ | 2X Annual Salary up to $700,000 | Paid by Employer |

**Long-Term Disability Coverage Election**

| Employee Coverage Only | Enroll | Decline | Benefit Amount | Premium Amount |
|---|---|---|---|---|
| Long-Term Disability | ☒ | ☐ | 60% up to $6,000 | Provided by Employer |

**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.