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: **Northwest Arkansas Community College**

Group ID: **G000AN68**	Sub Group ID: **0001**	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:

Voluntary Short-Term Disability Coverage Election

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

Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Long -Term Disability	■	□	$_____	Paid by Employer

Basic Life and AD&D Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	■	□	$_____	Paid by Employer

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	$_____
	☐	$50,000	$_____
	☐	$70,000	$_____
	☐	$100,000	$_____
	☐	Other $ _____	$_____
	☐	Decline	
Voluntary Life and AD&D - Spouse	☐	$10,000	$_____
	☐	$15,000	$_____
	☐	$20,000	$_____
	☐	$30,000	$_____
	☐	Other $ _____	$_____
	☐	Decline	
Voluntary Life - Child	☐	$10,000 (per child)	$_____ (all children)
	☐	Decline	

If you are enrolling for Voluntary Term Life coverage in excess of the Guarantee Issue Amount of 5x your annual salary up to $100,000 or if your spouse is enrolling for coverage in excess of $30,000, 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.

The following eligibility guidelines apply for dependent coverage:

- You must be age 69 or less for your dependent spouse to be eligible for coverage. Coverage terminates when you (the employee) attain the age of 70. If premium is paid for spouse coverage after you attain age 70, the premium will be refunded in accordance with the terms of the policy.

- Your dependent children must be under age 19 (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 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.

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 AR, CO, DC, KS, KY, LA, ME, NC, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT, and WA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)

Arkansas/Maine/Ohio/Tennessee 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.

I understand that payment of premium does not ensure my eligibility for coverage.

☐ ** I understand that checking this box constitutes a legal signature