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| **Enrollment Form** | | | | | | | | | | | | | | **Brought2uMoo** | | |
| **United of Omaha Life Insurance Company**  Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175 Phone: (800) 948-9478 | | | | | | | | | | | | | |
| **Policyholder/Employer Section** (To be completed by the policyholder/employer. Required fields are marked with an asterisk (\*).) | | | | | | | | | | | | | | | | |
| \*Policyholder/Employer Name: **Custom Hardware Engineering & Consulting, Inc.** | | | | | | Effective Date: | | | | Group ID: **G000AN97** | | | | | | |
| Sub Group ID: | Location Code: | | | | | Class: | | | | Occupation: | | | | | | |
| \*Salary: | | | \*Date of Hire: | | | | | Hours Worked Per Week: | | | | | | | | |
| **Employee/Member 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: | | | | | | E-mail Address: | | | | | | | | | | |
| \*City: | | \*State: | | | | \*Zip Code: | | | | | Telephone: ( ) - | | | | | |
| **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. | | | | | | | | | | | | | | | | |
| \*Have you (the employee/member) used tobacco in any form (ex. cigarettes or chewing tobacco) within the past 12 months? 🞏 Yes 🞏 No | | | | | | | | | | | | | | | | |
| \*Has your spouse used tobacco in any form (ex. smoking cigarettes or chewing tobacco) within the past 12 months? 🞏 Yes 🞏 No 🞏 NA | | | | | | | | | | | | | | | | |
| **Voluntary Critical Illness/Specified Disease Coverage Election** | | | | | | | | | | | | | | | | |
| **Important eligibility information:** To be eligible for Critical Illness/Specified Disease insurance, you (the employee/member) and any dependent(s)‎ must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage. | | | | | | | | | | | | | | | | |
| **If you (the employee/member) are age 70 or older:** The guaranteed amount available without answering health questions (Guarantee Issue Amount) and the Voluntary Critical Illness/Specified Disease benefit amount(s) available to you and your spouse (if applicable)‎ are subject to a benefit reduction due to age. At age 70, the guaranteed amount and the benefit amount(s) available under this plan decrease to 50% of the original amount. When a benefit amount decreases, the premium amount also decreases. If you are age 70 or older, the benefit amount(s) shown below for you and your spouse are already reduced. | | | | | | | | | | | | | | | | |
| **Employee/Member and Dependent Coverage** | | | | | | | **Benefit Amount –**  **Select One Option** | | | | | **Semi-Monthly Premium Amount** (**Per Paycheck - 24/Year)** | | | | |
| **Non-Tobacco Users** | | | | **Tobacco Users** |
| Voluntary Critical Illness/Specified Disease – Employee/Member   * Child(ren) are automatically enrolled for 25% of your elected benefit amount, for no additional charge. | | | | | | | 🞏 $5,000 | | | | | $\_\_\_\_\_\_\_\_ | | | | $\_\_\_\_\_\_\_\_ |
| 🞏 Other $\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | $\_\_\_\_\_\_\_\_ | | | | $\_\_\_\_\_\_\_\_ |
| 🞏 Decline | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | |
| Voluntary Critical Illness/Specified Disease – Spouse   * The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount. | | | | | | | 🞏 $5,000 | | | | | $\_\_\_\_\_\_\_\_ | | | | $\_\_\_\_\_\_\_\_ |
| 🞏 Other $\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | $\_\_\_\_\_\_\_\_ | | | | $\_\_\_\_\_\_\_\_ |
| 🞏 Decline | | | | |  | | | | |
| If you are enrolling for Voluntary Critical Illness/Specified Disease coverage in excess of the Guarantee Issue Amount of $5,000, or if your spouse is enrolling for coverage in excess of$5,000, you must complete and submit an evidence of insurability form. The form is available from the policyholder/employer, or is available online at http://www.mutualofomaha.com/eoi. | | | | | | | | | | | | | | | | |
| The following applies to dependent Voluntary Critical Illness/Specified Disease coverage:   * You (the employee/member) must elect coverage for yourself for your dependent(s) to be eligible. * Use of the term “spouse” for critical illness/specified disease coverage refers to the person to whom you (the employee/member) are legally married, or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live. * Your dependent child(ren) must be under age 26 to be eligible for insurance. | | | | | | | | | | | | | | | | |
| **Voluntary Accident Coverage Election** | | | | | | | | | | | | | | | | |
| **Important eligibility information:** To be eligible for Accident insurance, you (the employee/member) and your dependent(s), if applicable, must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage. | | | | | | | | | | | | | | | | |
| **Employee Only Coverage** | | | | | | | **Select One Coverage Option** | | | | | **Semi-Monthly Premium Amount** (**Per Paycheck - 24/Year)** | | | | |
| VoluntaryAccident – Employee/Member Only | | | | | | | 🞏 | | | | | $8.45 | | | | |
| Voluntary Accident – Employee/Member + Spouse | | | | | | | 🞏 | | | | | $12.08 | | | | |
| Voluntary Accident – Employee/Member + Child(ren) | | | | | | | 🞏 | | | | | $14.45 | | | | |
| Voluntary Accident – Employee/Member + Family | | | | | | | 🞏 | | | | | $19.01 | | | | |
|  | | | | | | | 🞏 Decline | | | | |  | | | | |
| The following applies to Voluntary Accident coverage:   * Your employer pays 0% of the premium for this coverage. The premium amounts above reflect your contribution. * Use of the term “spouse” for accident coverage refers to the person to whom you (the employee/member) are legally married, or if the policyholder/employer allows or as required by law, your domestic or civil union partner or equivalent, as allowed by federal or state law, or law of the county, city or local government where you live. * Your dependent child(ren) must be under age 26 to be eligible for insurance. | | | | | | | | | | | | | | | | |

**PAGE 1 OF 2 FORM CONTINUES ON PAGE 2**

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| **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. Certain states are community property states. If you live in one of these states and you designate someone other than your spouse as a beneficiary, state law may require that your spouse consent to the designation. Community property states currently include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin. 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. | | | | | | | |
| **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  Percent |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| 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  Percent |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Percentage Total: | | | | | | | 100% |
| **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.  If I am a resident of Rhode Island and am electing critical illness insurance, by signing below I also acknowledge that I have read the “Notice for Residents of Rhode Island Electing Critical Illness Insurance” provided below.  **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.)* | | | | | | | |

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