Enrollment Form

Brought to you by:

Mutual of Omaha

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: **Lagoon Pumping & Dredging, Inc.**		Effective Date:	Group ID:
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary:	*Date of Hire:	Hours Worked Per Week:	

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:	*Marital Status:
*Street Address:	E-mail Address:		
*City:	*State:	*Zip Code:	Telephone: ( ) -

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Basic Life and AD&D - Employee	☑	☐	$_____	Paid by Employer

Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Short-Term Disability	☑	☐	$_____ per Week	Paid by Employer

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Long-Term Disability	☑	☐	$_____ per Month	Paid by Employer

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. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information. 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	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	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 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 ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment 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 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** ____/____/____

Designation of Beneficiary Form

Mutual of Omaha

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name:	Group ID:

Employee/Member 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:	*Marital Status:

*Street Address:	Email Address:

*City:	*State:	*ZIP Code:	Telephone: ( ) -

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

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. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

SIGNATURE OF EMPLOYEE/MEMBER _____ **DATE**_____/_____/_____