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: **Diocese of Tyler**			
Group ID: **G000426E**	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

Basic Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Premium Amount
Basic Life and AD&D - Employee	■	☐	Paid by Employer
Basic Life - Spouse	☐	☐	Paid by Employer
Basic Life - Child(ren)	☐	☐	

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	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 represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. 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 dependents 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 decline coverage(s), I understand and accept the Waiver of Group Insurance provisons that follow.

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.

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