Enrollment Form

Brought to you by: Mutual of Omaha

Underwritten by: United of Omaha Life Insurance Company

Employer Section

Employer's Name: **Toledo Electrical Welfare Fund**	Effective Date:	Group ID: **G000ABZ7**

Member Section (Please print clearly. Required fields are highlighted in yellow.)

Last Name: **0**	First Name: **0**	MI:
Social Security Number:	Birth Date (MM/DD/YYYY):	Gender: / Marital Status:
Street Address:	E-mail Address:	
City: / State:	Zip Code:	Telephone: ( ) -

Voluntary Term Life Coverage Member Election

Select from Option 1 or Option 2

OPTION 1

Choose two benefit amounts paying premiums from your Supplemental Fringe Benefit Fund AND from your checking or savings account (EFT)

You may select up to $40,000 to be paid thru the Supplemental Fringe Benefit Fund.

Benefit Amount Select One Option	Monthly Premium Amount - SFBF
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ Other_____ ☐ Decline	$_____

You may also select up to $110,000 benefit with premiums paid thru Electronic Funds Transfer.

Benefit Amount Select One Option	Monthly Premium Amount - EFT
☐ $10,000 ☐ $30,000 ☐ $70,000 ☐ $110,000 ☐ Other_____ ☐ Decline	$_____

OPTION 1 Elections Total Benefit & Premium

SFBF Amount	+	EFT Amount	Total Benefit	SFBF Premium	+	EFT Premium	Monthly Premium
$		$	$	$		$	$

OPTION 2

Elect one benefit amount with premiums withdrawn from your checking or savings account through EFT on the 1st or 15th of each month

Choose up to $150,000 with premiums paid thru electronic funds transfer (EFT).

Benefit Amount Select One Option*	Monthly Premium Amount - EFT
☐ $20,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ Other_____ ☐ Decline	$_____

Voluntary Term Life Coverage for Dependents***

Spouse Options**	☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other_____ ☐ Decline	$_____
Child(ren) Option***	☐ $10,000 (per child) ☐ Other_____ ☐ Decline	$0.65 (all children) $_____

The following eligibility guidelines apply for dependent coverage:

***Dependents cannot enroll for coverage in excess of 50% of amount elected by you (the member).**
**You must be age 69 or less for your dependent spouse to be eligible for coverage. Spouse coverage terminates when you (the member) attain the age of 70. If any 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 child(ren) must be under age 21 (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.

FORM CONTINUES ON PAGE 2

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	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%

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 benefit and premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the benefit plan as well as your salary and age on the effective date of the plan.

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 decline coverage(s), I understand and accept the Waiver of Group Insurance provisions 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** _____/_____/_____

Waiver of Group Insurance

Should I apply for waived coverage(s) in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, **at my own expense**.

The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

If you would like to elect a benefit amount that is not listed on the enrollment form, please contact the fund office at 419-666-4450.

Before you submit your enrollment materials to United of Omaha, be sure to complete the following:

1. Designate your Beneficiary(ies).
2. Sign and date the enrollment form.
3. Complete the Electronic Funds Transfer form and attached voided check, if applicable.