Group Term Life/Disability Enrollment Form

You will be using this form to enroll in new coverage, change your current coverage or make changes to you demographic information.

GROUP TERM LIFE/DISABILITY Enrollment Form
Companion Life Insurance Company
(providing Life Insurance Coverage)
Mutual of Omaha Insurance Company
(providing Disability Insurance Coverage)

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

*Employer Name: Otsego Northern Catskills BOCES		Effective Date:	Group ID:
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee 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:			
*City:	*State:	*Zip Code:	

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Weekly Premium Amount (52/Year)
Voluntary Life and AD&D - Employee	☐ $20,000 ☐ $50,000 ☐ $70,000 ☐ $100,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Spouse	☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child) ☐ Other $_____ ☐ Decline	$0.35 (all children) $_____

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000. In no event shall your amount of insurance exceed 5 times your salary.
- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Weekly Premium Amount (52/Year)
Voluntary Long-Term Disability	☐	☐	_____ per Month	$_____

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

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. 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)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

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 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 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.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **The Fraud Warning does not apply to life insurance benefits.**

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.

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

Applicable to Life Plans for Residents of New York

- Read your policy carefully.
- Your employer may include a Living Care (Accelerated Death) Benefit in your plan. If so, there is no additional premium charge associated with this benefit. Receipt of such benefits may affect your eligibility for public assistance programs, and the benefits received may be taxable as income.
- Certain war risks are not assumed. In case of any doubt contact the insurance company for further explanation.