

# Enrollment Form

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Mutual of Omaha

Underwritten by: Companion Life Insurance Company  
Mutual of Omaha Insurance Company

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

*Employer's Name: Long Island Cares, Inc.		*Effective Date:	Group ID: G000AK3T
Sub Group ID:	Location Code:	Class:	*Occupation:
*Salary: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly \$ <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Annually	*Date of Hire:		Hours Worked Per Week:

**Employee Section** (Please print clearly. Required fields are marked with an asterisk(\*).)

**Enrollment ID: 2995**

*Last Name:		*First Name:		MI:
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	*Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
*Street Address:		E-Mail Address:		
*City:	*State:	*Zip Code:	Telephone:	

**Long-Term Disability Coverage Election**

Employee Coverage Only	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Long-Term Disability	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

■ Your Employer pays 99% of the premium for this coverage. The premium amount above reflects your contribution.

**Basic Life and AD&D Coverage Elections**

Employee Only Coverage	Enroll	Decline	Benefit Amount	Monthly Premium Amount (12/Year)
Basic Life - Employee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ _____	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	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 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. 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**

**Additional Information**

**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 the Living Care benefit. Receipt of Living Care (Accelerated Death Benefit) may affect eligibility for public assistance programs and may be taxable.
- Certain war risks are not assumed. In case of any doubt write your company for further explanation.

**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.