Enrollment Form – Voluntary Life Insurance

Underwritten by: United of Omaha Life Insurance Company

Employer Section (To be completed by the employer/plan administrator.)

Employer:	City of Fargo	Effective Date	Group ID
Department	Date of Hire	Hours Worked Per Week	

Employee Section (Please print clearly)

Last Name	First Name	MI	
Social Security Number	Birth Date (MM/DD/YYYY)	Sex	Marital Status

Voluntary Life and AD&D Coverage Election

COVERAGE	Select benefit amount for yourself and, if desired, for spouse and/or dependent children.		Monthly Premium
Employee	☐ \$10,000 ☐ \$20,000 ☐ \$30,000 ☐ \$40,000 ☐ \$50,000 ☐ \$ 60,000 ☐ \$ 70,000 ☐ \$ 80,000 ☐ \$ 90,000 ☐ \$100,000 ☐ \$110,000 ☐ \$120,000 ☐ \$130,000 ☐ \$140,000 ☐ \$150,000 ☐ \$160,000 ☐ \$170,000 ☐ \$180,000 ☐ \$190,000 ☐ \$200,000	☐ Decline	\$ ________
Spouse	☐ \$ 5,000 ☐ \$10,000 ☐ \$15,000 ☐ \$20,000 ☐ \$25,000 ☐ \$30,000 ☐ \$35,000 ☐ \$40,000 ☐ \$45,000 ☐ \$50,000 ☐ Decline	• Coverage for spouse cannot exceed 50% of the Employee's amount. • Rate for spouse coverage is based on *employee's age* as of effective date. • Spouse may apply for up to \$100,000 of insurance, but coverage exceeding \$50,000 requires medical approval. Contact Human Resources for more information.	\$ ________
Dependent Children	☐ \$10,000 ☐ Decline	• Employee must have at least \$20,000 of insurance in order to cover dependent children. • Dependent, unmarried children can be covered until age 22, or age 26 if full-time student. • Each dependent child will have \$10,000 of life insurance coverage.	\$1.10 (this rate covers all children)

- You must be age 69 or less for your dependent spouse to be eligible for coverage. Spouse coverage terminates when you (the employee) 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.
- Coverage for your 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.

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. Employee is the beneficiary of the spouse and children.

Primary Beneficiary(s) Designation

Last Name	First Name	Relationship to Insured	Age	Address of Beneficiary (if known)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary(s) Designation (To whom benefit is paid if Primary Beneficiary dies before, or at the same time as the employee.)

Last Name	First Name	Relationship to Insured	Age	Address of Beneficiary (if known)	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.