

Enrollment Form

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: Lake County			
Group ID: G000ABAJ	Sub Group ID:	Location Code:	Class:
*Full-Time Employment Date:		Effective Date:	Hours Worked Per Week:
*Salary: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly	Occupation:		
\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Annually			

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Married <input type="checkbox"/> Widowed
*Street Address:		E-mail Address:		
*City:	*State:	*Zip Code:		

Long-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Long -Term Disability				
▪ Core Plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$ _____	Paid by Employer
▪ Buy-Up Plan	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

Voluntary Short-Term Disability Coverage Election

Employee Only Coverage	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Short-Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

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

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 subjects such person to criminal and civil penalties.