

# LTD/VSTD Enrollment Form

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Underwritten by: United of Omaha Life Insurance Company



Mutual of Omaha

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

|  |                |                                   |             |           |
|--|----------------|-----------------------------------|-------------|-----------|
| *Employer's Name: <b>Lake County Board of County Commissioners</b> |                | *Effective Date: <b>10/1/2010</b> |             | Group ID: |
| Sub Group ID:  | Location Code: | Class:                            | Occupation: |           |
| *Salary:   | *Date of Hire: | Hours Worked Per Week:            |             |           |

**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: | Marital Status: |

**Long Term Disability Coverage Election**

| Employee Only Coverage | Enroll                              | Decline                  | Benefit Amount                          | Semi-Monthly Premium Amount (Per Paycheck) |
|------------------------|-------------------------------------|--------------------------|---|--|
| Long-Term Disability   |                                     |                          |   |  |
| ▪ Core Plan            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | \$_____ per Month (180 day elimination) | Paid by Employer                           |
| ▪ Buy-Down Plan        | <input type="checkbox"/>            | <input type="checkbox"/> | \$_____ per Month (90 day elimination)  | \$_____                                    |

**Voluntary Short Term Disability Coverage Election**

| Employee Only Coverage          | Enroll                   | Decline                  | Benefit Amount   | Semi-Monthly Premium Amount (Per Paycheck) |
|---------------------------------|--------------------------|--------------------------|------------------|--|
| Voluntary Short-Term Disability | <input type="checkbox"/> | <input type="checkbox"/> | \$_____ per Week | \$_____                                    |

**Enrollment Information**

Enrollment must occur within 30 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 based on your salary as of 10/01/2008.

**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 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.