Enrollment Form

Group Premium and Enrollment Services
Underwritten by: United of Omaha Life Insurance Company

To Be Completed By Employer Or Plan Sponsor

Employer's Company Name **City** **State** **Zip**
Sub Group Name ________________ **Location Code** ________________
Group I.D. **Sub Group I.D.** ________ **Class** ________ **Effective Date** ___/___/___ **Current Base Pay $** ________
☐ Hourly ☐ Weekly ☐ Biweekly
☐ Monthly ☐ Semimonthly ☐ Annually

To Be Completed By Employee (Please Print)

Social Security Number ____-____-____ Name ________ (Last) ________ (First) ____ (M.I)

Birth Date ____/____/____ (Mo. Day Yr.) Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Widow

Hire Date ____/____/____ (Mo. Day Yr.) Hours worked per week______ Full-Time Employment Date ____/____/____ (Mo. Day Yr.)

Street Address________________ Zip Code________

City________________ State________

Home Phone________ Work Phone________ Occupation________

Employee Election

	Yes
Long Term Disability (LTD)	☐
Short Term Disability (STD)	☐
Life/AD&D	☐

Instructions: Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, form **MUST** be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee________________________ **Date**____/____/____