Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

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

*Employer Name: Arrowhead Economic Opportunity Agency, Inc.		Effective Date:	Group ID: G000C7BL
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

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

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	E-mail Address:		
*City:	*State:	*Zip Code:	Telephone: ( ) -

Voluntary Life Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Bi-Weekly Premium Amount (26/Year)
Voluntary Life - Employee	☐ $10,000	$_____
	☐ $30,000	$_____
	☐ $50,000	$_____
	☐ $80,000	$_____
	☐ $100,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life - Spouse	☐ $5,000	$_____
	☐ $10,000	$_____
	☐ $15,000	$_____
	☐ $25,000	$_____
	☐ Other $_____	$_____
	☐ Decline	
Voluntary Life - Child(ren)	☐ $10,000 (per child)	$0.92 (all children)
	☐ Other $_____	$_____
	☐ Decline	

You must complete and submit an Evidence of Insurability form if you or your spouse are enrolling for Voluntary Term Life coverage in excess of the Guaranteed Issue Amount (GIA). The form is available from your employer/benefits administrator, or is available online at http://www.mutualofomaha.com/eoi. The GIA is the lesser of 5 times your annual salary, or $100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or $25,000. In no event shall your amount of insurance exceed 5 times your salary.

- You must elect coverage for yourself for your dependent(s) to be eligible.
- The benefit amount elected for your child(ren) cannot be more than 100% of your elected benefit amount.
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount.
- Your dependent spouse must be age 70 or less for your spouse to be eligible for coverage. Coverage terminates when your spouse reaches the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Basic Life and AD&D Coverage Election

Employee and Dependent Coverage	Enroll	Decline	Benefit Amount	Bi-Weekly Premium Amount (26/Year)
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer
Basic Life - Spouse	☐	☐	$7,500	$0.69
Basic Life - Child(ren)	☐	☐	$5,000 (per child)	$0.69

The following applies to dependent Basic Life coverage:
- The premium amount for spouse and child(ren)is blended – the same premium amount applies whether spouse coverage, child(ren) coverage, or both is/are selected.
- The Child(ren) Benefit Amount listed applies to any child age six months or older. A different benefit amount may apply to any child under the age of six months. Please contact your employer/benefits administrator for additional information.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If you need to list more dependents than space will allow, please include this information on a separate piece of paper and submit it with this form.

Name of Dependent: Last name	First Name	Gender	Relationship to Employee	Birth Date (MM/DD/YYYY)

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable 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 applicable policy as well as your age and/or salary on the effective date of the coverage.

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 guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that 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 apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable 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 summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable 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. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Term Life Insurance

FOR EMPLOYEES OF ARROWHEAD ECONOMIC OPPORTUNITY AGENCY, INC.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES	Minimum	Guarantee Issue	Maximum
For You	$10,000	5 times annual salary, up to $100,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $25,000	100% of employee's benefit, up to $250,000
Children	$2,500	$10,000	100% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.

FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $375,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).

Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 40%
- At age 75, amounts reduce to 20%

Spouse coverage terminates at age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.28	$0.55	$0.83	$1.11	$1.38	$1.66	$1.94	$2.22	$2.49	$2.77
30 - 34	$0.32	$0.65	$0.97	$1.29	$1.62	$1.94	$2.26	$2.58	$2.91	$3.23
35 - 39	$0.46	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62
40 - 44	$0.74	$1.48	$2.22	$2.95	$3.69	$4.43	$5.17	$5.91	$6.65	$7.38
45 - 49	$1.25	$2.49	$3.74	$4.98	$6.23	$7.48	$8.72	$9.97	$11.22	$12.46
50 - 54	$1.98	$3.97	$5.95	$7.94	$9.92	$11.91	$13.89	$15.88	$17.86	$19.85
55 - 59	$3.14	$6.28	$9.42	$12.55	$15.69	$18.83	$21.97	$25.11	$28.25	$31.38
60 - 64	$4.98	$9.97	$14.95	$19.94	$24.92	$29.91	$34.89	$39.88	$44.86	$49.85
65 - 69	$7.80	$15.60	$23.40	$31.20	$39.00	$46.80	$54.60	$62.40	$70.20	$78.00
70+	$12.28	$24.56	$36.84	$49.13	$61.41	$73.69	$85.97	$98.25	$110.53	$122.82

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your spouse's age,** so find your spouse's age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.14	$0.28	$0.42	$0.55	$0.69	$0.83	$0.97	$1.11	$1.25	$1.38
30 - 34	$0.16	$0.32	$0.48	$0.65	$0.81	$0.97	$1.13	$1.29	$1.45	$1.62
35 - 39	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31
40 - 44	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69
45 - 49	$0.62	$1.25	$1.87	$2.49	$3.12	$3.74	$4.36	$4.98	$5.61	$6.23
50 - 54	$0.99	$1.98	$2.98	$3.97	$4.96	$5.95	$6.95	$7.94	$8.93	$9.92
55 - 59	$1.57	$3.14	$4.71	$6.28	$7.85	$9.42	$10.98	$12.55	$14.12	$15.69
60 - 64	$2.49	$4.98	$7.48	$9.97	$12.46	$14.95	$17.45	$19.94	$22.43	$24.92
65 - 69	$3.90	$7.80	$11.70	$15.60	$19.50	$23.40	$27.30	$31.20	$35.10	$39.00

ALL CHILDREN PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)*

$2,500	$5,000	$7,500	$10,000
$0.23	$0.46	$0.69	$0.92

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.