Voluntary Enrollment Form

Underwritten by: Mutual of Omaha Insurance Company

Employer Section

Company Name: **San Diego and Imperial County Fringe Benefits Consortium**				
City:			State:	Zip Code:
School Name:			Location Code:	
Group I.D.:	Sub-group I.D.:	Class:	Effective Date:	Hours worked per week:
Current Base Pay $	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually		Full-Time Employment Date:	Occupation:

Employee Section (Please Print)

Social Security:	Name: Last First M.I.	
Birth Date: Mo. Day Yr.	Gender: ☐ Male ☐ Female	Marital Status:
Street Address:		
City:	State:	Zip Code:

Voluntary AD&D Coverage Election T66BA-P-51402 Review & Check As Applicable

		Yes	No	Benefit Amount	Premium Amount
Voluntary AD&D	Employee Only	☐	☐	$__________	$__________
Voluntary AD&D	Employee & Family	☐	☐	$__________	$__________

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship	Birth Date Mo. Day Yr.	Social Security Number
Spouse:				
Child(ren):				

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured.

(If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)

Primary Beneficiary Last Name	First	M.I.	Relationship to Insured	**Secondary Beneficiary** Last Name	First	M.I.	Relationship to Insured
______	______	___	______	______	______	___	______
______	______	___	______	______	______	___	______

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. **Should you decline coverage(s) for either yourself or your eligible dependent(s), you MUST complete the Waiver of Group Voluntary Insurance on the back of this form**.

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**______/______/______

MUG6673

Waiver of Group Voluntary Insurance

I have been given the opportunity to apply for Group Voluntary AD&D Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll:

For:
- ☐ Myself (and all eligible dependents, if applicable)
- ☐ My eligible dependent spouse only
- ☐ My eligible dependent spouse and children only
- ☐ My eligible dependent children only

I understand and accept the Waiver of Group Insurance provisions.

Signature of Employee____**Date**________/________/________

Insurance Company Use Only

Acknowledgement____Date Recorded _______/________/________