

**ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
ENROLLMENT FORM**

Brought to you by:



for
State of Michigan
Policy Number: G000AAXP

Underwritten by: Mutual of Omaha Life Insurance Company

Applicant Name: _____ **Social Security Number:** ____-____-_____

Employee ID #: _____ **Date of Birth:** ____ / ____ / ____

Date of Hire: ____ / ____ / ____

Spouse Name: _____ **Spouse Date of Birth:** ____ / ____ / ____

If you wish to enroll, elect one of the following coverage options.

(Please check the box for the desired principal sum amount for you, your spouse, and child(ren).)

Employee		Spouse		Child(ren)	
Principal Sum	Biweekly Deduction	Principal Sum	Biweekly Deduction	Principal Sum	Biweekly Deduction
<input type="checkbox"/> \$15,000.00	\$0.21	<input type="checkbox"/> \$15,000.00	\$0.21	<input type="checkbox"/> \$15,000.00 (per child)	\$0.21 (all children)
<input type="checkbox"/> \$30,000.00	\$0.42	<input type="checkbox"/> \$30,000.00	\$0.42	Note: This amount will cover all eligible dependents regardless of number of eligible children	
<input type="checkbox"/> \$60,000.00	\$0.84	<input type="checkbox"/> \$60,000.00	\$0.84		
<input type="checkbox"/> \$120,000.00	\$1.68	<input type="checkbox"/> \$120,000.00	\$1.68		
<input type="checkbox"/> \$240,000.00	\$3.36	<input type="checkbox"/> \$240,000.00	\$3.36		
<input type="checkbox"/> \$300,000.00	\$4.20	<input type="checkbox"/> \$300,000.00	\$4.20		

*Spouse coverage cannot exceed 100% of employee election.

SEE INSTRUCTIONS ON THE BACK OF THIS FORM.

Insured Member's Designation of Beneficiary

PRIMARY BENEFICIARY

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

SECONDARY BENEFICIARY

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

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 if I am not currently enrolled and seeking coverage for the first time or increasing coverage, I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage.

I certify that all statements are true to the best of my knowledge and belief and I understand a copy of this form will be made available at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective.

When complete, please mail or fax this form to:
Mutual of Omaha Insurance Company Or FAX to: 402-997-1999
Attn: Group Policy Services
Mutual of Omaha Plaza
Omaha, NE, 68175-5842

Employee Signature: _____ Date: ____ / ____ / ____

If you have questions on this offering, please contact 800-283-9591 Monday through Friday from 8:00 AM to 5:00 PM (CST).

Instructions: Please complete your Beneficiary Designation form and advise your designated beneficiary that you have done so. For your designation to be valid, you must sign and date the form.

List your beneficiary under the PRIMARY BENEFICIARY section; be sure to include their name and their relationship to you.

You may also list a SECONDARY BENEFICIARY. This beneficiary will receive the benefit in the event that your primary beneficiary is deceased. Please be sure to include their name and their relationship to you.

Where a beneficiary is related to the insured by blood or marriage, the relationship should be inserted, e.g., husband, wife, son, daughter, father, mother, grandfather, grandmother, uncle, aunt, cousin, foster-mother, sister-in-law, half-brother, etc. Where a beneficiary is not related to the insured by blood or marriage, any other relationship should be inserted, e.g., business associate, partner, creditor, fiancée, former wife, etc.

If you do not designate a beneficiary, the payment of benefits will default to the provisions of the contract.

If you have any questions, please call the Mutual of Omaha Service Center at 1-800-283-9591.

Mutual of Omaha Insurance Company
Attn: Group Policy Services
Mutual of Omaha Plaza
Omaha, NE, 68175-5842

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