Enrollment Form

Brought to you by:

Underwritten by: United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company

Employer Section

Employer's Name: **Miracle Restaurant Group**				
City:			State:	Zip Code:
Sub Group Name:			Location Code:	
Group I.D.: **G000109E**	Sub-group I.D.:	Class:	Effective Date: **08/01/2006**	Hours worked per week:
Salary: $	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually		Full-Time Employment Date:	Occupation:

Employee Section (Please Print)

Social Security:		Full Name:	
Birth Date:	Age:	Gender: (Male or Female) _____	Marital Status:
Street Address:			
City:		State:	Zip Code:

Basic Life and AD&D Coverage

		Yes
Basic Life	Employee	X

Disability Coverage

Employee Only	**Yes**
Long Term Disability	X

Voluntary Life Coverage Election — Review & Check As Applicable

		Yes	No	Benefit Amount	Premium Amount
Voluntary Life	Employee	☐	☐	$_____	$_____
Voluntary Life	Spouse	☐	☐	$_____	$_____
Voluntary Life	Child(ren)	☐	☐	$_____ (each child)	$_____ (each child)

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship[1]	Birth Date[2] Mo. Day Yr.	Social Security Number
Spouse:				
Child(ren):				

See your benefits administrator for the required form(s):
[1]If the dependent(s) listed is not your natural child, please complete the Statement of Responsibility for a Dependent Child form and submit with this enrollment form.
[2]If dependent is over the limiting age as specified in your plan provisions and a full-time student, complete a Student Dependent Attendance Report form and submit with this enrollment form.

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: Enrollment must occur 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 Insurance that follows.**

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**_____/_____/_____

Waiver of Group Insurance (Should you decline coverage(s) for either yourself or your eligible dependent(s), you **MUST** complete and sign this section.)

I have been given the opportunity to enroll for Group Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll in the following coverage(s):

☐ Voluntary Life

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

Reason: ☐ Cannot afford
☐ Other Reason_____

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s), I understand that my dependent(s) and I may be considered a late enrollee(s) and must submit evidence of insurability, at my own expense.

Dental Coverage: Late enrollee(s) may be subject to Benefit Waiting Periods.

The above requirements will apply unless otherwise stated in the plan, or unless prohibited by any applicable state or federal law.

I understand and accept the Waiver of Group Insurance provisions.

SIGNATURE OF EMPLOYEE_____ **DATE**_____/_____/_____

Insurance Company Use Only Acknowledgement_____ Date Recorded_____/_____/_____