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: Applied Mechanical Systems, Inc		Effective Date:	Group ID: G000AQUX
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Member 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: ( ) -

Short-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Short-Term Disability	☒	☐	_____ per Week	Paid by Employer

Voluntary Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Voluntary Long-Term Disability	☐	☐	_____ per Month	$_____

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer

Voluntary Life and AD&D Coverage Election

Employee and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount
Voluntary Life and AD&D - Employee	☐ $20,000 ☐ $50,000 ☐ $70,000 ☐ $100,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Spouse	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $35,000 ☐ Other $_____ ☐ Decline	$_____ $_____ $_____ $_____ $_____
Voluntary Life and AD&D - Child(ren)	☐ $10,000 (per child) ☐ 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 $35,000. 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.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 21, or under age 25 if a full-time student, to be eligible for insurance.

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 member 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 MEMBER _____ **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.)*

Ohio Fraud Warning: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

LIFE, SHORT TERM DISABILITY & VOL. LIFE

Mutual of Omaha

Group Life (Company-paid)

- Term Life Benefit Amount: $15,000
- Accidental Death & Dismemberment Benefit Amount: $15,000

Short Term Disability (Company-paid)

- Up to 60% of pre-disability earnings to a maximum of $600 per week.
- Maximum benefit period of 24 weeks
- Elimination Period, benefit begins: 15th day of disabling injury / 15th day of disabling illness

Voluntary Life (Employee-paid)

- **Employee Benefit - $250,000 maximum or 5x annual salary**

  Guarantee Issue (initial enrollment): 5x annual salary up to $100,000

- **Spouse Benefit - 100% of employee benefit to a maximum of $50,000**

  Guarantee Issue (initial enrollment): $35,000

- **Child(ren) Benefit - $10,000**
- **Accidental Death & Dismemberment Benefit** – 75% of Vol. Life benefit up to $100,000
- **Age Reduction** – 65% at age 70 / 45% at age 75 / 30% at age 80
- **Portable** - Yes

EMPLOYEE PREMIUM TABLE (52 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	$0.32	$0.65	$0.97	$1.29	$1.62	$1.94	$2.26	$2.58	$2.91	$3.23
30 - 34	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69
35 - 39	$0.42	$0.83	$1.25	$1.66	$2.08	$2.49	$2.91	$3.32	$3.74	$4.15
40 - 44	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
45 - 49	$0.97	$1.94	$2.91	$3.88	$4.85	$5.82	$6.78	$7.75	$8.72	$9.69
50 - 54	$1.48	$2.95	$4.43	$5.91	$7.38	$8.86	$10.34	$11.82	$13.29	$14.77
55 - 59	$2.24	$4.48	$6.72	$8.95	$11.19	$13.43	$15.67	$17.91	$20.15	$22.38
60 - 64	$3.42	$6.83	$10.25	$13.66	$17.08	$20.49	$23.91	$27.32	$30.74	$34.15
65 - 69	$6.02	$12.05	$18.07	$24.09	$30.12	$36.14	$42.16	$48.18	$54.21	$60.23
70 - 74	$10.66	$21.32	$31.98	$42.65	$53.31	$63.97	$74.63	$85.29	$95.95	$106.62
75 - 79	$17.49	$34.98	$52.48	$69.97	$87.46	$104.95	$122.45	$139.94	$157.43	$174.92
80+	$35.26	$70.52	$105.78	$141.05	$176.31	$211.57	$246.83	$282.09	$317.35	$352.62

VOLUNTARY LONG TERM DISABILITY

ELIGIBILITY - VLTD ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by you.
BENEFITS	
Elimination Period	Your benefits begin on the later of 180 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per month during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.

VOLUNTARY LONG-TERM DISABILITY PREMIUM CALCULATION

Use the rates in the Age/Premium Factor Table to calculate your premium for voluntary long-term disability coverage in the worksheet below, using the example as a guide.

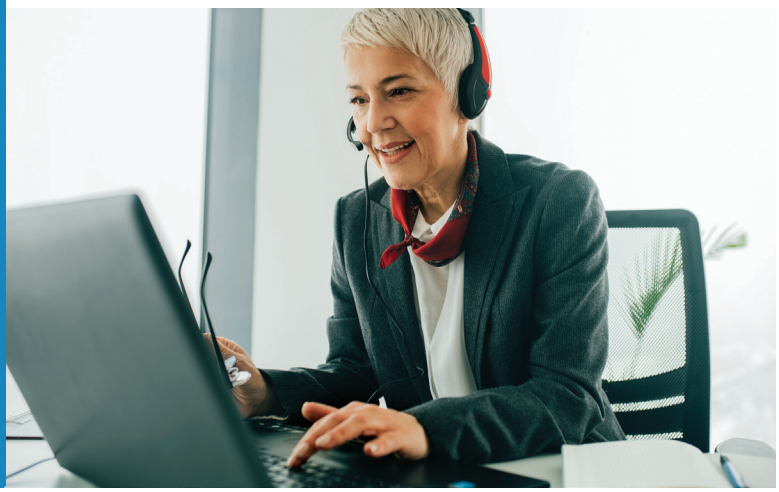
WEEKLY PREMIUM CALCULATION		EXAMPLE *(42-year-old employee earning $40,000 a year)*
List your monthly earnings (Maximum is $8,333.33)	$ _____	$ *3,333.33*
Multiply by the premium factor	_____	*0.0010846*
Your Estimated Weekly Premium**	$ _____	$ *3.62*

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

AGE	PREMIUM FACTOR
< 20	0.0001615
20 - 24	0.0001846
25 - 29	0.0003000
30 - 34	0.0004385
35 - 39	0.0006462
40 - 44	0.0010846
45 - 49	0.0018231
50 - 54	0.0031385
55 - 59	0.0041308
60 - 64	0.0043385
65 - 69	0.0045692
70+	0.0047769

Employer Access

Guide to Submitting Member Enrollment Requests



Managing employee benefits can be time consuming. But Mutual of Omaha offers quick, convenient options that simplify plan administration.

Secure Online Plan Administration

Spend less time on paperwork and expedite transactions with our secure online portal. Through Employer Access, you can quickly and easily enroll, update or terminate employee coverage from a single screen.

Once you log in to the secure portal:

- Click on the "Members" tab and search for the member's name
- Access functions such as updating eligible employee roster, sending Evidence of Insurability (EOI), and editing or terminating employees
- Click the green "New Enrollment" button to add new employees

Employees who were terminated and rehired need to be added to the roster via a request to our service team.

Questions or Need Assistance?

Contact your Dedicated Service Team.

Not registered to use our portal?

If you are not a registered user of Employer Access, go to **mutualofomaha.com**.

1) Click on **Sign In**

2) Select **Plan Administrator**

3) Click the **Sign Up Button** *(bottom of the screen)*

See the next page for more convenient enrollment options!

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Options When Using Paper Enrollment

Enrollment Form

If you prefer using the paper enrollment process, each employee must complete and sign an enrollment form.

Enrollment forms must be filled out completely to avoid delays in processing; required fields are marked with an asterisk (*). Return completed forms to your Dedicated Service Team.

Note: A new hire enrollment form was included in your welcome email.

Excel Spreadsheet

If you prefer to capture new employee information in a spreadsheet format, Mutual of Omaha will accept an Excel file. To expedite your request, please include the information listed here.

Type of Change Requested (Hires, Qualifying Life Event, etc.)

Effective Date of Change

- Member's First and Last Name
- Date of Birth (Employee and Spouse)
- Date of Hire or Rehire
- Signature Date (Contributory/Voluntary)
- SSN (optional but strongly preferred for Dental/Vison)
- Salary: Annual or Hourly
- Hours Worked per Week
- Coverage Elections by Product
- Tobacco Status, if Applicable
- Class (if more than one class)
- Bill Group (if receiving separate bills)
- Location Code (if receiving one bill and employees are itemized by location/department)
- Termination Date (last date worked)

Dental & Vision Benefits Require:

- Address
- Dependents: First and Last Name, Date of Birth & Gender

Important

We must receive all required information before completing the enrollment process.

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