Enrollment Form

Underwritten by: United of Omaha Life Insurance Company

Employer's Name: **Warrick County Government**	Effective Date: 01/01/2020	Group ID: G000AT66

***Last Name:**	***First Name:**	***Gender:**
***Employee SSN:**	***Employee Date of Birth:**	
***Home Street Address:**		
***Home City:**	***Home State:**	***Home Zip:**

Voluntary Vision Coverage Election

	Benefit Amount: Select One Option	**Your Cost Per Pay (24 deductions per year)**
☐	Employee Only	$ 3.14
☐	Employee + Spouse	$ 7.22
☐	Employee + Child(ren)	$ 8.00
☐	Employee + Family	$ 12.22
☐	**Decline/Waive Coverage**	

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

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

Enrollment Information

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

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 ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life 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 insurance company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the 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 summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the 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.