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: Massachusetts Park Corporation dba Massachusetts Technology Collaborative		Effective Date:	Group ID: G000AYS9
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee 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:			
*City:	*State:	*Zip Code:	

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

Long-Term Disability Coverage Election				
Employee Coverage Only	**Enroll**	**Decline**	**Benefit Amount**	**Premium Amount**
Long-Term Disability	☒	☐	_____ per Month	Provided by Employer

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

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. 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	Benefit Percent (%)
1						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
2						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
3						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
					Percentage Total:	100%

Secondary Beneficiary Designation

#	Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN	Benefit Percent (%)
1						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
2						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
3						
	Telephone:	Address of Beneficiary (Address, City, State, Zip):				
					Percentage Total:	100%

Enrollment Information

Enrollment must occur within 31 days from the date the employee 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.

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 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. *(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.)*

Massachusetts 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 claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.