



## **Western Area School Health Benefit Plan Enrollment Directions**

### **RED PLAN**

All eligible employees should complete the attached applications for medical and voluntary life.

Employees may elect Dental and/or Vision if they are enrolled in the Medical Plan. The Dental and Vision elections can be at a different level than the Medical benefit. For example, an employee may have employee +2 Medical coverage, employee + 3/more Dental coverage and employee only Vision coverage.

Reminder – All eligible employees should complete the voluntary life insurance application. To accept or decline the coverage, the application that is included must be completed.



**Things You Should Know:**

1. **AUTHORIZATION FOR PAYROLL DEDUCTION AND EMPLOYEE ACKNOWLEDGEMENT:** I hereby request the insurance indicated for myself and/or my dependents and hereby authorize my employer to make deductions from my earnings of any required contributions to apply toward the premiums for the insurance provided in the policy or group insurance issued to my employer. All information given by me on this form is true and complete. I have read and understand all the information included on this form. I understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
2. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I agree to the following terms for myself and my dependents: We authorize, if permitted by law, health care providers, insurers, claims administrators and employers to provide medical, employment and benefit information, including information relating to drug, alcohol, or psychiatric histories and treatment, to the Plan Administrators or their representatives. The Plan Administrators and their representatives may share such information and provide it to other insurers and claims administrators only for the purpose of administering group coverage and claims for benefits, utilization review, provider peer review and the resolution of grievances. This authorization shall be valid for the term of coverage. I acknowledge that I have obtained a copy of this authorization. I agree that a reproduced copy of this authorization will be as valid as the original.
3. **WAIVER OF COVERAGE:** This is to certify that I have been given an opportunity for coverage available to me and my family members through my employer and I have decided to waive my right to coverage at this time. I understand that I may later enroll for medical coverage or any other coverage, if in the presence of a family status change or at open enrollment. I have read and understand the following with regard to special enrollments. I understand that it is my responsibility to report to my employer any change in my family (or individual) status.

Please indicate the type of coverage you are waiving:

- Medical//Drug Card
- Dental
- Vision

Reason for waiving coverage:

- Other Group Medical Coverage     Other Group Dental Coverage     Other Group Vision Coverage
- Other: \_\_\_\_\_

**I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each dependent name as covered under the Medical Benefits plan is considered a “dependent” as defined in the plan.**

**Employee Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Please return the completed form to the Insurance Representative/Bookkeeper at your School/Agency’s central office.**

**LOCATION CODES**

<b>040</b>	Beardstown	CUSD #15
<b>003</b>	Central	CUSD #3
<b>007</b>	Dallas	ESD #327
<b>009</b>	Fulton Co (Cuba)	CUSD #3
<b>031</b>	Havana	CUSD #126
<b>041</b>	Illini West	HSD #307
<b>014</b>	LaHarpe	CSD #347

<b>016</b>	Liberty	CUSD #2
<b>017</b>	Mendon	CUSD #4
<b>039</b>	Midwest Central	CUSD #191
<b>033</b>	Payson	CUSD #1
<b>019</b>	Pikeland	CUSD #10
<b>020</b>	Pleasant Hill	CUSD #3
<b>050</b>	Regional Office of Ed	#1
<b>051</b>	Regional Office of Ed	#26
<b>052</b>	Regional Office of Ed	#33

<b>025</b>	Southeastern	CUSD #337
<b>027</b>	Spoon River Valley	CUSD #4
<b>028</b>	VIT	CUSD #2
<b>029</b>	West Central IL Special Ed Coop	
<b>035</b>	West Prairie	CUSD #103
<b>010</b>	Western Area Career System	

# Enrollment Form

## United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175



<b>Employer Section</b> (To be completed by the employer. Required fields are marked with an asterisk(*).)			
*Employer Name: Trustees of Western Area School Employee Benefits Trust		Effective Date:	Group ID: G000BXYB
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Annually	*Date of Hire:		Hours Worked Per Week:

<b>Employee Section</b> (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:	

<b>Basic Life and AD&amp;D Coverage Election</b>			
<b>Employee Coverage Only</b>	<b>Enroll</b>	<b>Decline</b>	<b>Benefit Amount</b>
Basic Life and AD&D - Employee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
			Paid by Employer

<b>Voluntary Life and AD&amp;D Coverage Election</b>		
<b>Employee and Dependent Coverage</b>	<b>Benefit Amount - Select One Option</b>	<b>Monthly Premium Amount</b>
Voluntary Life and AD&D - Employee	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$130,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> Other \$ _____ <input type="checkbox"/> Decline	\$ _____ \$ _____ \$ _____ \$ _____ \$ _____
Voluntary Life and AD&D - Spouse	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$35,000 <input type="checkbox"/> Other \$ _____ <input type="checkbox"/> Decline	\$ _____ \$ _____ \$ _____ \$ _____
Voluntary Life and AD&D - Child(ren)	<input type="checkbox"/> \$10,000 (per child) <input type="checkbox"/> Decline	\$2.00 (all children)

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 \$200,000. 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. (Maximum of \$10,000)
- The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount. (Maximum of \$150,000)
- You must be less than age 80 for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 80.
- Your dependent child(ren) must be under age 26 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):
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**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):
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**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. 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 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](http://www.mutualofomaha.com).)