

Voluntary Enrollment Form

Underwritten by: Mutual of Omaha Insurance Company



Employer Section					
Company Name: MERCED COUNTY OFFICE OF EDUCATION SISC Voluntary AD&D Program					
City: MERCED			State: CA		Zip Code: 95341
Sub Group Name: MERCED COUNTY OFFICE OF EDUCATION			Location Code:		
Group I.D.:	Sub-group I.D.:	Class:	Effective Date:		Hours worked per week:
Current Base Pay \$	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually	Full-Time Employment Date:		Occupation:	
Employee Section (Please Print)					
Social Security:		Name: Last First M.I.			
Birth Date: Mo. Day Yr.		Gender: ☐ Male ☐ Female		Marital Status:	
Street Address:					
City:		State:		Zip Code:	
Voluntary AD&D Coverage Election Review & Check As Applicable					
		Yes	No	Benefit Amount	Premium Amount
Voluntary AD&D	Employee Only	☐	☐	\$ _____	\$ _____
Voluntary AD&D	Employee & Spouse	☐	☐	\$ _____	\$ _____
Voluntary AD&D	Employee & Child(ren)	☐	☐	\$ _____	\$ _____
				Total Premium	\$ _____
Dependent Information (Please Print)					
Name of Dependent(s)	Gender	Relationship	Birth Date Mo. Day Yr.	Social Security Number	
Spouse:					
Child(ren):					
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			Secondary Beneficiary		
Last Name	First	M.I. Relationship to Insured	Last Name	First	M.I. Relationship to Insured
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Instructions: Application must be made 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 Voluntary Insurance on the back of this form.					
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 Voluntary Insurance

I have been given the opportunity to apply for Group Voluntary AD&D Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll:

For: ☐ Myself (and all eligible dependents, if applicable)
☐ My eligible dependent spouse and children only

☐ My eligible dependent spouse only
☐ My eligible dependent children only

I understand and accept the Waiver of Group Insurance provisions.

Signature of Employee _____

Date _____ / _____ / _____

Insurance Company Use Only

Acknowledgement _____ Date Recorded _____ / _____ / _____