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 *Employer Name: Bell Concrete/Lamar Companies				d fields a	elds are marked with an asterisk(*).) Effective Date:			Group ID: G000BWW2			
Sub Group ID: Location Code:					Class:			Occupation:			
* <mark>Salary:</mark> \$	□ Hourly □ Monthly	U Weekly Semi-Monthly	Bi-We		*Date of Hire:			Hours Worked Per Week:			
Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)											
*Last Name	*Last Name: MI:										
*SSN/ID Nu	mber:		* <mark>Birth Dat</mark>	e (MM/DD/YYYY): *G				ender: *Marital Status:			
*Street Addr	ess:		I	E-mail Address:							
*City:		*State:		*Zip Code:				Telephone: () -			
Tobacco Us	se Section (If you o	to not complete this	section, toba	acco pre	miums will apply	. Required fields	s are ma	rked with an	asteris	sk(*).)	
	se to the following										
								Employee		Spouse	
*In the last 1	2 months, have ye	ou smoked a ciga	rette, cigar	or pipe	; chewed tobad	cco; or used		□ Yes		☐ Yes	
tobacco or n	icotine in any othe	er form (including	forms of nic	cotine re	eplacement)?		🗆 No		🗆 No		
Voluntary C	Critical Illness/Sp	ecified Disease	Coverage E	lectior	า						
Health Insu	rance Informatio	n for Critical IIIn	ess and Ac	cident	Insurance Or	ıly					
						Employee		Spouse		Child(ren)	
For Residents of CA Only: Does each person proposed for insura individual or group policy or contract that arranges or provides med surgical coverage not designed to supplement other private or gove (Any person without such comprehensive coverage is ineligible for				dical, ho ernment	spital, and tal plans?	□ Yes □ No		□ Yes □ No		□ Yes □ No	
									Wee	kly	
Employee and Dependent Coverage Benefit Amount - Select One Option											
		oronago						Premium Amount			
Voluntary C	ritical Illnoon/Spool	ified Disease En		□ \$5.000				(52/Year) \$			
Voluntary Critical Illness/Specified Disease - Employee				□ \$3,000 □ \$10,000				\$\$			
					5,000			\$		_	
					20,000			\$		—	
				□ Other \$				\$			
Voluntary Critical Illness/Specified Disease - Spouse				□ \$5,000				\$			
				□ \$20,000				\$			
				□ Other \$				\$			
					ecline						
The following applies to Voluntary Critical Illness/Specified Disease coverage:											
 You must elect coverage for yourself for your dependent(s) to be eligible. The benefit amount elected for your spouse cannot be more than 100% of your elected benefit amount. 											
	re automatically enro										
- Your depend	- Your dependent child(ren) must be under age 26 to be eligible for insurance.										
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Voluntary Accident Coverage Election Important eligibility information: To be eligible for Accident insurance, you the employee and your dependent(s), if applicable, must have major medical insurance, or a combination of basic hospital and basic medical insurance. Any person that does not have such insurance is ineligible for and should not elect this coverage.

				Weekly		
Employee and Dependent Coverage	Sele	ct One Coverage Option	Premium Amount			
				(52/Year)		
Voluntary Accident - Employee Only				\$2.39		
Voluntary Accident - Employee + Spouse				\$3.47		
Voluntary Accident - Employee + Child(ren)				\$5.13		
Voluntary Accident - Employee + Family				\$6.57		
			Decline			
The following applies to Voluntary Accident coverage: - Your dependent child(ren) must be under age 26 to b	o oligiblo fo	ringurango				
Voluntary Short-Term Disability Coverage Ele		insulance.				
				Weekly		
Employee Coverage Only	Enroll	Decline	Benefit Amount			
		200		Premium Amount (52/Year)		
Voluntary Short-Term Disability			per Week	\$		
Voluntary Long-Term Disability Coverage Ele	ction			*		
				Weekly		
Employee Coverage Only - NOT OFFERED	Enroll	Decline	Benefit Amount			
				Premium Amount (52/Year)		
Voluntary Long-Term Disability			per Month	\$		
Voluntary Life and AD&D Coverage Election						
				Weekly		
Employee and Dependent Coverage		Benefit /	Amount - Select One Option	Premium Amount		
				(52/Year)		
Voluntary Life and AD&D - Employee		D Retain	Current Amount	\$		
- Current Benefit Amount:		□ \$20,00	00	\$		
		□ \$50,00	00	\$		
		□ \$70,00	00	\$		
		□ \$100,0	000	\$		
		□ Other \$	\$	\$		
		Decline	e			
Voluntary Life and AD&D - Spouse		Retain	Current Amount	\$		
- Current Benefit Amount:		□ \$5,000)	\$		
		□ \$10,00	00	\$		
		□ \$15,00	00	\$		
		□ \$25,00	00	\$		
		□ Other \$	\$	\$		
		Decline	e			
Voluntary Life and AD&D - Child(ren)			0	•		
		L Retain	Current Amount	\$		
- Current Benefit Amount:			Ourrent Amount 00 (per child)	» \$0.51 (all children)		
- Current Benefit Amount:		□ \$10,00		\$\$0.51 (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 \$100,000. For your spouse, the GIA is the lesser of 100% of the amount you enroll for, or \$25,000. 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 100 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 100.

- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Basic Life and AD&D Coverage Election

Employee Coverage Only Enroll Decline Benefit Amount Promium Amount (g2)vent Basic Life and AD&D - Employee 03								Weekly		
Basic Life and AD&D - Employee Image: Contrast of the second	Employee Coverage Only	En	roll	Decline	Benefit Amount			Premium Amount		
Dental Coverage Select One Coverage Option Weekly Penalum Amount (s2Year) Penalum Amount (s2Year) Penalum Amount (s2Year) Dental - Employee Only Dental - Employee + Spuse Dental - Employee + Shuff(ern) Bit 44 9 (s22.18) Dental - Employee + Family Bit 44 9 (s22.18) The following applies to Dental coverage: - Your employer pays a portion of the premium for this coverage. The premium amounts above reflect your contribution. - Your dependent Indirgen) must be under age 26 to be eligible for insurance. Dependent Information (if you enroled dependents for insurance, you must complete this section. Pease print Cearry) If you need to list more dependents than space will allow, please induced this information on a separate please print Cearry) It will with this form. If you need to list more dependents than space will allow, please induced bits information on a separate please of paper and submit if with this form. It will be please that is a separate signed and dated sheet. Beneficiary be signed and dated sheet. Beneficiary be administrator to additional information. Primary Beneficiary Designation First Name Relationship Bit Print Additionship Bi										
Select One Coverage Option Weekly Promium Amount (s2/vear) Dental - Employee Only Dental - Employee - Child(ren) 37.11 Dental - Employee - Spouse 313.33 Dental - Employee - Child(ren) 313.33 Dental - Employee - Tamily Decine The following applies to Dental coverage:			×					Paid by Empl	oyer	
Employee and Dependent Coverage Select One Coverage Option Promium Amount (s2/Year) Dental - Employee Only Dental - Employee + Spouse Dental - Employee + Spouse Dental - Employee + Family Image: State of Stat	Dental Coverage Election							We	okly	
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Dental - Employee + Spouse								(52/Year)		
Dental - Employee + Spouse	Dental - Employee Only					п		\$ 7 11		
Dental - Employee + Family										
Decline D										
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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.*)

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.



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!



Content is subject to change. Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Products are not available in all states. Each company is solely responsible for its own contractual and financial obligations.

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.

