SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Voluntary Term Life Insurance Enrollment Form Underwritten by Mutual of Omaha

EMPLOYEE SECTION

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)	MI	GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YYYY)	STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.

VOLUNTARY LIFE COVERAGE ELECTION

Voluntary Life Coverage	Benefit Amount	Monthly Premium Amount (12/Year)
Employee	$_____	$_____
Spouse/Domestic Partner	$_____	$_____
Dependent Child(ren)	$_____	$_____

Employee: Newly hired employees (within 31 days of hire date or 31 days of being newly eligible) are Guaranteed an Issue Amount (GIA) of up to $150,000 of Voluntary Term Life Insurance (VTL). Any amounts submitted after 31 days require evidence of insurability, which can be done at www.mutualofomaha.com/EOI.

Spouse: Spouse (within 31 days of employee hire date or 31 days of being newly eligible) is Guaranteed an Issue Amount (GIA) of 100% of the employee's benefit, up to $25,000 of Voluntary Term Life Insurance (VTL). Any amounts submitted after 31 days require evidence of insurability, which can be completed at www.mutualofomaha.com/EOI. You must elect coverage in order for your spouse and dependents to be eligible. Spouse age is based on employee age as of policy anniversary date for premium and eligibility purposes.

The following eligibility guidelines apply for dependent coverage:
**Your dependent child(ren) must be under age 26. If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy.

BENEFICIARY FOR DEATH BENEFITS (Right to change beneficiary is reserved to the insured.)

Primary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Son, Daughter, etc.)	DATE OF BIRTH	ADDRESS OF BENFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE (%)
				Percentage Total	100%

Secondary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Son, Daughter, etc.)	DATE OF BIRTH	ADDRESS OF BENFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE (%)
				Percentage Total	100%

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 dependents 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 decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

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.

EMPLOYEE _____ **DATE** _____/_____/_____

WAIVER OF GROUP INSURANCE

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)); I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own cost.

TO BE COMPLETED BY DISTRICT

DISTRICT NAME:	DISTRICT ID #:

HIRE DATE:	EFFECTIVE DATE:	HOURS WORKED PER WEEK:	JOB CLASSIFICATION:

DISTRICT SIGNATURE:	DATE: