

State Board for Community Colleges and Occupational Education Voluntary AD&D Enrollment Form



Underwritten by: Mutual of Omaha Insurance Company

Employer Section

Company Name: **State Board for Community Colleges and Occupational Education**

City: Denver	State: CO	Zip Code: 80230
---------------------	------------------	------------------------

College/Agency Name:

Group I.D.: T66BA-P-51585	Class: 0001	Effective Date:	Hours worked per week:
-------------------------------------	-----------------------	-----------------	------------------------

Current Base Pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Annually	Benefit Eligibility Date:	Occupation:
---	---------------------------	-------------

Employee Section (Please Print)

Social Security:	Name: Last First M.I.
------------------	--

Birth Date: Mo. Day Yr.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Voluntary AD&D	Employee & Family	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship	Birth Date			Social Security Number
			Mo.	Day	Yr.	
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.

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 _____ / _____ / _____