Enrollment Form

Brought to you by:

Underwritten By:

United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
United Concordia Insurance Company (for Dental plans only)

Employer Section (APC will complete this section upon submission of this form)

Employer's Name:
Alliance of Professionals and Consultants, Inc.

City:	State:	Zip Code:
Raleigh	**NC**	**27617**

Sub Group Name: NA	Location Code: NA

Group I.D.: G00079A8	Sub-group I.D.: NA	Class:	Effective Date:	Hours worked per week:

Salary: $	☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually	Full-Time Employment Date:	Occupation:

Employee Section (Please Print)

Full Name:

Birth Date:	Age:	Gender:	Marital Status:

Street Address:

City:	State:	Zip Code:

Long Term Disability Coverage

Employee Only	**Yes**	**No**
• Long Term Disability (Buy Up Option)	☐	☐

Note: As a Full Time employee, APC provides you with 40% income protection for up to 3 years following the date of the qualifying event. The Employee Buy-Up Option allows you to purchase an additional 20% of income protection and extends the term. This option ultimately protects a total of 60% of your income to Social Security normal retirement age.

Voluntary Life Coverage Election- Review & Check As Applicable

		Yes	**No**	**N/A**	**Benefit Amount**
Voluntary Life	Employee	☐	☐		$_____
Voluntary Life	Spouse	☐	☐	☐	$_____(Must_be_50%_Employee's_Coverage)
Voluntary Life	Child(ren)	☐	☐	☐	$_____

Have you used tobacco in any form (ex. smoking cigarettes or chewing tobacco) within the past 12 months? ☐Yes ☐No
Has your spouse used tobacco in any form (ex. smoking cigarettes or chewing tobacco) within the past 12 months?
☐Yes ☐No ☐NA NOTE: Amounts above Guarentee Issue will require an Evidence of Insurability form. See Benefit Summary.

Dependent Information (Please Print)

Name of Dependent(s)	**Gender**	**Relationship**	**Birth Date** Mo. Day Yr.	
Spouse:				
Child(ren):				

See your benefits administrator for the required form.
If dependent is over the limiting age as specified in your plan provisions and a full-time student, complete a Student Dependent Attendance Report form and submit with this enrollment form.

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 Last Name	First	M.I.	Relationship to Insured	**Secondary Beneficiary** Last Name	First	M.I.	Relationship to Insured

Instructions: Enrollment must occur by 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 I decline coverage(s) for either myself or my eligible dependent(s), I understand and accept the Waiver of Group Insurance provisions that follow.**

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**_____/_____/_____

Applicable To Life Plans
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 my dependent(s) and I may be considered late enrollees and must submit evidence of insurability, acceptable to the Insurance Company, at our own expense.

Voluntary Life: May require evidence of insurability.

The above requirements will apply unless otherwise stated in the plan, or unless prohibited by any applicable state or federal law.

Insurance Company Use Only Acknowledgement_____Date Recorded_____/_____/_____

THIS IS NOT AN APPLICATION FOR INSURANCE
This form is an enrollment form for the group insurance coverage acquired by your employer and the information you provide will not be used for underwriting purposes for such group insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.