Workplace Benefits Program

Payroll Deduction Authorization Form

To be completed by the employee if Payroll Deduction option is utilized.

NOTICE TO PRODUCER: Submit one completed and signed copy of this form to Mutual of Omaha Insurance Company with application.

Employer ____________________ **Group #** ____________ **Location** ______________

Instructions For Payroll Deduction

How often will deductions occur? (check one)

☐ Monthly ☐ Semi-Monthly (24 pay periods) ☐ Bi-weekly (26 pay periods)

☐ Weekly ☐ Other, please list number of deductions (annually and explain)________________

If any deductions will be skipped, please list the number of skipped deductions ____________________

If skipped deductions, what is the start date (month/day) for the skipped deductions? ________________

Please check box(es) below for the product(s) to be purchased and write the amount of each deduction:

☐ Critical Illness $__________ ☐ Lump Sum Cancer/Heart Attack & Stroke $ __________

☐ Disability $__________ ☐ Other $ ___________ Please List ____________________

Total deduction amount $ ______________ When will the first deduction start? (month/day) __________

Additional Instructions (complete when applicable):

Please change my total deduction amount from $__________ to $ ____________

Please discontinue my deduction effective (month/day) ____________________

Payment Deduction Authorization and Acknowledgments of Proposed Insured:

I here by authorize you, the employer, to deduct from any monies due me the total deduction amount indicated above and at the frequency indicated. I also request that you remit the appropriate amount to Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company/United World Life Insurance Company as indicated on the billing statement. If the total deduction amount is changed, either at my request or under the terms of the product(s), you are authorized to increase or decrease my total deduction amount as indicated on the billing statement. NOTE: I UNDERSTAND THAT THE INSURANCE COVERAGE FOR WHICH YOU DEDUCT THE PREMIUM FROM MONIES DUE ME, IS INDIVIDUAL, VOLUNTARY INSURANCE FOR WHICH NONE OR A PORTION OF THE PREMIUM IS PAID BY EMPLOYER, AND WHICH IS INDIVIDUALLY UNDERWRITTEN BASED ON MY INDIVIDUAL HEALTH CONDITIONS AND INFORMATION. I FURTHER UNDERSTAND THAT IF NO CASH (PREMIUM) IS COLLECTED WITH THE INSURANCE APPLICATION(S), NO COVERAGE WILL BE IN EFFECT UNTIL MY APPLICATION(S) IS/ARE APPROVED AND THE FULL INITIAL PREMIUM IS RECEIVED BY MUTUAL OF OMAHA INSURANCE COMPANY AND UNITED OF OMAHA LIFE INSURANCE COMPANY OR PIONEERING SERVICES CORPORATION, INC. It is understood that this authorization may be terminated by me or my employer at any time.

Signature ______________________________ Date ____________________

Waiver of Payroll Deduction Coverage

I (and all my eligible dependents) have been given the opportunity to apply for the insurance product(s) as offered and, after careful consideration, have decided not to apply for any insurance product(s).

Reason ____

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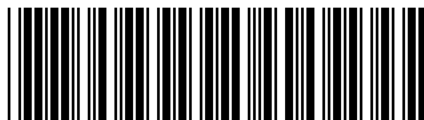
Should I decide to apply for insurance in the future, I understand and agree that all applicable underwriting requirements, including evidence of insurability, must be satisfied. I understand that Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, and United World Life Insurance Company reserve the right to reject such future insurance application(s), based on applicable underwriting guidelines.

Signature ______________________________ Date ____________________



Provide a copy to Home Office, Payroll Clerk and Applicant