Voluntary AD&D Insurance Enrollment Form

Underwritten by: United of Omaha Life Insurance Company

Independent Business Owners Benefits Association

State:

IBO Level:

□ Semiannually □ Annually

Describe Duties:

IBO Member Section Please print clearly.

Policyholder Section

Social Security Number:

Policyholder Name:

Last Name:

Street Address:

E-mail Address:

Occupation/Industry:

Application Type:

New Coverage

□ Coverage Change

□ Reapplying for Coverage

IBO Member and Dependent Coverage

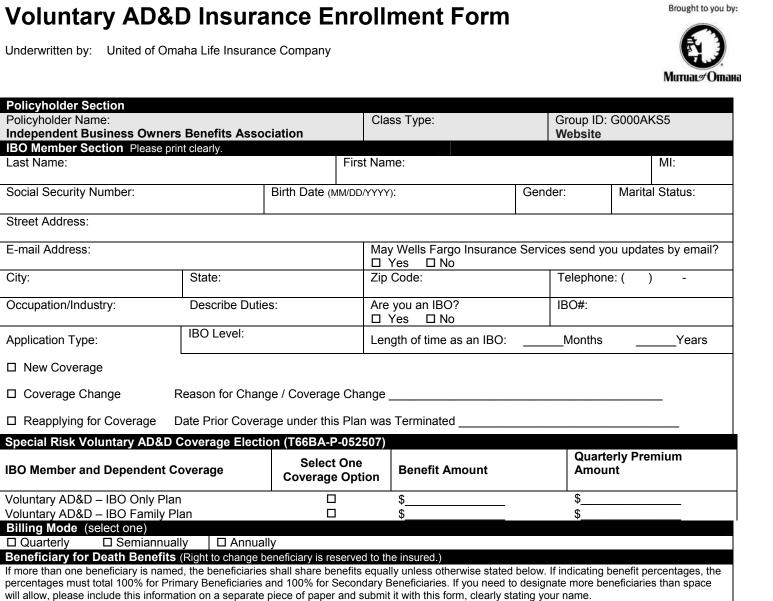
Voluntary AD&D – IBO Only Plan

Billing Mode (select one)

Quarterly

Voluntary AD&D – IBO Family Plan

City:



The beneficiary designation you indicate on the enclosed form will replace any prior beneficiary forms on file and become your new designation for th	е
entire amount of coverage under this group plan.	

charce amount of coverage ander this group plan.							
Primary Beneficiary Designation – receive(s) insurance proceeds in the event of your death.							
Last Name	First Name	Relationship to Insured	Date of Birth	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)		
	•			Percentage Total:	100%		
Secondary Beneficiary Designation – receive(s) insurance proceeds in the event that your Primary Beneficiaries have pre-deceased you.							
Last Name	First Name	Relationship to Insured	Date of Birth	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)		
Percentage Total:							

Enrollment Information

You are required to pay premiums for all coverage. 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 age on the effective date of your coverage.

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 insurance coverage for my eligible dependent(s) 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 apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply.

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

SIGNATURE OF IBO MEMBER

_ DATE ____/___

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. Wells Fargo Insurance Services is a licensed insurance agency representing and compensated by the insurer based on the amount of insurance sold. California License T66BA-P-52507

Mail completed enrollment forms to:

Wells Fargo Insurance Services USA, Inc. P.O. Box 338 Grand Rapids, MI 49501-0338