Voluntary AD&D Insurance Enrollment Form

Underwritten by: United of Omaha Life Insurance Company

Policyholder Section

Policyholder Name: **Independent Business Owners Benefits Association**	Class Type:	Group ID: G000AKS5 **Website**

IBO Member Section Please print clearly.

Last Name:	First Name:	MI:

Social Security Number:	Birth Date (MM/DD/YYYY):	Gender:	Marital Status:

Street Address:

E-mail Address:	May Wells Fargo Insurance Services send you updates by email? ☐ Yes ☐ No

City:	State:	Zip Code:	Telephone: ( ) -
Occupation/Industry:	Describe Duties:	Are you an IBO? ☐ Yes ☐ No	IBO#:

Application Type:	IBO Level:	Length of time as an IBO: ______Months ______Years

☐ New Coverage

☐ Coverage Change   Reason for Change / Coverage Change ____

☐ Reapplying for Coverage   Date Prior Coverage under this Plan was Terminated ___________________________________

Special Risk Voluntary AD&D Coverage Election (T66BA-P-052507)

IBO Member and Dependent Coverage	**Select One Coverage Option**	**Benefit Amount**	**Quarterly Premium Amount**
Voluntary AD&D – IBO Only Plan	☐	$________________	$________________
Voluntary AD&D – IBO Family Plan	☐	$________________	$________________

Billing Mode (select one)

☐ Quarterly ☐ Semiannually ☐ Annually

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. If you need to designate more beneficiaries than space will allow, please include this information on a separate piece of paper and submit it with this form, clearly stating your name.

The beneficiary designation you indicate on the enclosed form will replace any prior beneficiary forms on file and become your new designation for the entire amount of coverage under 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 (MM/DD/YYYY)	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 (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, Zip)	Benefit Percentage (%)
				Percentage Total:	100%

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