Enrollment Form
United of Omaha Life Insurance Company

KPC National Office, 1825 Orleans Ave. New Orleans, LA 70116

Policyholder Section (To be completed by the policyholder. Required fields are marked with an asterisk(*).)

*Policyholder Name: Knights of Peter Claver, Inc.	Effective Date:	Group ID: G000AMYG

Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:

*Council/ Court Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:

*Street Address:

*City:	*State:	*Zip Code:

Life and AD&D Coverage Election

Member and Dependent Coverage	Benefit Amount - Select One Option	Premium Amount (auto draft)
Life and AD&D - Member	☐ $ 2,500 ☐ $5,000 ☐ Decline	$ 9.00 per month $ 17.00 per month
Life - Spouse	☐ $1,000 ☐ Decline	$ 3.00 per month
Life - Child(ren)	☐$1,000 (per child) ☐Decline	$ 3.00 per month

- You must elect coverage for yourself for your dependent(s) to be eligible.
- You must be age 70 or less for your spouse to be eligible for coverage. Spouse coverage terminates when you reach the age of 70.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.
- If you choose the $5,000 option, it will reduce to $2,500 once you reach age 70.

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

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)
Telephone:	Address of Beneficiary (Address, City, State, Zip):		

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)
Telephone:	Address of Beneficiary (Address, City, State, Zip):		

Enrollment Information

Enrollment must occur within 31 days from the date the member becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated. Any premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the 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 guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage. I understand and agree that life 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 underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable 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 summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF 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. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

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

AD & D Pricing for Supplemental Life Insurance

		Premium			
Member Coverage	**Benefit**	**Monthly**	**Quarterly**	**Semi-Annual**	**Annual**
Life and AD&D - Member	**$2500**	**9.00**	**36.00**	**54.00**	**100.00**
	$5000	**17.00**	**68.00**	**102.00**	**200.00**
Dependent Coverage					
Life and AD&D - Spouse	**$1000**	**3.00**	**12.00**	**18.00**	**36.00**
Life - Child(ren)	**$1000** ***(per child)***	**3.00**	**12.00**	**18.00**	**36.00**

ACH Recurring Payment Authorization Supplemental Life Insurance

Billing Details

Billing Address ____ Phone# ___________________________

City, St, Zip ____

Email ____

Credit Card Information ○ **VISA** ○ **MasterCard** ○ **AMEX** ○ **Discover**

Cardholder's Name ____

Credit Card **#** _________ -_________-_________-_______ Expiration Date ____/____ Security Code _____

Bank (ACH) Information ○ Checking ○ Savings

Name on Account ____Bank ______________________________

Routing# _______________________________________ Acct# _______________________________________

You can also provide your banking information using the link provided in your welcome email.

I authorize the above The Knights of Peter Claver to charge the account indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Individual's Signature ____ **Date** ____________________