

Basic Life/Voluntary Life Change Form

Underwritten by: United of Omaha Life Insurance Company



Brought to you by:



Mutual of Omaha

Instructions - Complete and sign below. Return completed form to your Employer.

Type of Change

BASIC LIFE Beneficiary Change - VOLUNTARY LIFE Beneficiary Change
 Both BASIC/SUPPLEMENTAL Beneficiary Change
 NAME CHANGE - Previous Name _____

Employer Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk (*).)

*Employer's Name: ANTELOPE VALLEY UNION HIGH SCHOOL DISTRICT

District Name: AVUHSD District #: 64246 Group ID: G000ABIH

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

*Last Name _____ *First Name: _____ MI: _____

*Social Security Number: _____ *Birth Date (MM/DD/YYYY): _____ *Gender: Male Female
 Marital Status: Single Married Divorced Widowed

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

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

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

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%

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. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.

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.

SIGNATURE OF EMPLOYEE _____ DATE ____/____/____