AAAS employee benefit fund

AAAS Employee Benefit Fund
11245 Chantilly Parkway Court
Pike Road, AL 36064
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Mutual of Omaha

LIFE - Application for Enrollment/Changes

GROUP
G000AK2Z

Employer Company Name				Employer Phone Number
Employee Name (Last)	(First)	(Initial)		Employee Phone Number
Street Address	City	State	Zip	Employee Date of Birth

CHECK ONE:	CHECK ONE:		Employee's Social Security Number	Date of Hire
❍ Male	❍ Single	❍ Divorced		
❍ Female	❍ Married	❍ Widowed		

SELECT PLAN, COVERAGE & AMOUNT:		AMOUNT OF INSURANCE		
		EMPLOYEE	SPOUSE	CHILDREN ELIGIBLE
❍ Plan A-1* *EOI Mandatory	❍ Employee Only Coverage	$100,000		
	Dependent Coverage: ❍ Yes ❍ No	$100,000	$2,000	$250/$1,000
❍ Plan A	❍ Employee Only Coverage	$50,000		
	Dependent Coverage: ❍ Yes ❍ No	$50,000	$2,000	$250/$1,000
❍ Plan B	❍ Employee Only Coverage	$25,000		
	Dependent Coverage: ❍ Yes ❍ No	$25,000	$2,000	$250/$1,000
❍ Plan C	❍ Employee Only Coverage	$10,000		
	Dependent Coverage: ❍ Yes ❍ No	$10,000	$2,000	$250/$1,000

Beneficiary Information

Primary Beneficiary's Name (Last) (First) (Initial)		Relationship of Beneficiary	Social Security Number
Street Address	City	State	Zip
Contingent Beneficiary's Name (Last) (First) (Initial)		Relationship of Beneficiary	Social Security Number
Street Address	City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you.
If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

I hereby request the amount of insurance coverage for which I am or may become eligible under the insurance policy issued by Mutual of Omaha and authorize the deduction from my earnings of the amount required to cover my share of the premiums, if any. I reserve the right to revoke this deduction authorization at any time on written notice. I am actively at work with the employer at least 30 hours per week.

SIGNATURE OF EMPLOYEE	DATE OF SIGNATURE	REQUESTED START DATE

AAASEBF Use Only		
Effective Date		A