

Detach and return



To enroll for the Group Accident Plan, return this completed form to:

Compass Rose Benefits Group

P.O. Box 8816

Reston, VA 20195

Attn: GAP

Mutual of Omaha Insurance Company

# ENROLLMENT FORM FOR GROUP ACCIDENT INSURANCE

## ENROLLEE INFORMATION (PLEASE PRINT)

Enrollee's Name (First, Middle, Last) \_\_\_\_\_ Telephone Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Agency \_\_\_\_\_

The bi-weekly premium for each \$10,000 of the Principal Sum amount you select is as follows:

- Employee Only Coverage: \$.31
- Employee and Family Coverage: \$.45

Please select a Principal Sum from \$10,000 to \$300,000, in increments of \$10,000:

Employee Only                      Principal Sum \$ \_\_\_\_\_

Employee and Family              Principal Sum \$ \_\_\_\_\_

If no beneficiary designation is made, benefits are payable to your estate.

## PRIMARY BENEFICIARY DESIGNATION

Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (City, State, Zip) \_\_\_\_\_

Percentage \_\_\_\_\_

Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (City, State, Zip) \_\_\_\_\_

Percentage \_\_\_\_\_

## CONTINGENT SECONDARY BENEFICIARY DESIGNATION

Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (City, State, Zip) \_\_\_\_\_

Percentage \_\_\_\_\_

Name (First, Middle, Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address (City, State, Zip) \_\_\_\_\_

Percentage \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_