

# Enrollment Form

Group Premium and Enrollment Services  
Underwritten by: Mutual of Omaha Insurance Company



## To Be Completed By Employer Or Plan Sponsor

Employer's Company Name: Wasco County

City: The Dalles

State: OR

Zip: 97058

Sub Group Name: Wasco County

Location Code: N/A

Group I.D.	Sub Group I.D.	Class	Effective Date	Current Base Pay \$
<b>G00034B9</b>	<u>0001</u>	<u>A001</u>	____/____/____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Annually

## To Be Completed By Employee (Please Print)

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name \_\_\_\_\_  
Last First M.I.

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female Marital Status:  Single  Married  Divorce  Widow  
Mo. Day Yr.

Hire Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Hours worked per week \_\_\_\_\_ Full-Time Employment Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Yr. Mo. Day Yr.

Street Address \_\_\_\_\_ Zip Code \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_

## Employee Election

Yes

Long Term Disability (LTD)

Instructions: Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, form MUST be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_