Long-Term Disability and Term-Life Insurance Enrollment Form

Brought to you by:

Underwritten by: United of Omaha Life Insurance Company

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

National Rural Letter Carriers' Association	*Effective Date:	Group ID:

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

*Last Name:	*First Name:	MI:	*Birth Date (MM/DD/YYYY):
*Social Security Number:	USPS Employee ID #		Finance #
*Telephone Number:	*E-mail Address:		Salary:

Voluntary Life Coverage Election - Member and Dependent Coverage

Voluntary Life - Member	**Benefit Amount Select One Option**	**Bi-Weekly Premium Amount**	**Benefit Amount Select One Option**	**Bi-Weekly Premium Amount**
To calculate Voluntary Life rates, click here.	☐ $25,000 ☐ $50,000 ☐ $75,000	$__________ $__________ $__________	☐ $100,000 ☐ Other $________ ☐ Decline	$__________ $__________

If you are enrolling for Voluntary Term Life coverage in excess of the Guarantee Issue Amount of 5 times your annual salary or $100,000 (whichever is less), or if your spouse is enrolling for coverage in excess of $50,000, you must complete and submit an Evidence of Insurability form. The form is available from your employer, or is available online at http://www.mutualofomaha.com/customer_service/group_plan_member/forms.html.

Voluntary Life - Spouse*	**Benefit Amount**	**Bi-Weekly Premium Amount**	**Benefit Amount**	**Bi-Weekly Premium Amount**
To calculate Voluntary Life rates, click here.	☐ $25,000	$__________	☐ $50,000 ☐ Decline	$__________

***In order to purchase coverage for your spouse, you must purchase coverage for yourself**. You must be age 69 or less for your dependent spouse to be eligible for coverage. Spouse coverage terminates when you (the employee) attain the age of 70. If any premium is paid for spouse coverage after you attain age 70, the premium will be refunded in accordance with the terms of the policy

Voluntary Life - Child(ren)**	**Benefit Amount**	**Bi-Weekly Premium Amount**
To calculate Voluntary Life rates, click here.	☐ $10,000 (per child) ☐ Decline	$0.92 (all children)

** **In order to purchase coverage for your child(ren), you must purchase coverage for yourself**. Your dependent child(ren) must be under age 21 (under age 25 if a full-time student). If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy.

Voluntary Long-Term Disability Coverage Election

Member Coverage Only	**Enroll**	**Benefit Amount**	**Bi-Weekly Premium Amount**
Voluntary Long-Term Disability – 50% Monthly Benefit	☐	$__________	$__________
Voluntary Long-Term Disability – 60% Monthly Benefit	☐	$__________	$__________
Decline	☐		

To calculate Voluntary Long-Term Disability rates, click here.

Determining Your Total Bi-Weekly Premium for Payroll Deduction

Transfer that Amount to the Allotment form, #5b. on page 3

__________ + __________ + __________ + __________ + **.50** = __________

Member VTL Premium + Spouse VTL Premium + Child VTL Premium + VLTD Premium + Admin. Fee = **Total Premium**

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

If more than one beneficiary is named, the beneficiaries shall share benefits 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. If you need to designate more beneficiaries than space will allow, please include this information on a separate piece of paper and submit it with this form, clearly stating your name.

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%

Contingent 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%

Enrollment Information

Enrollment must occur within 31 days from the date the member becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form MUST be signed and dated to authorize payroll deductions. The benefit and premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the benefit plan as well as your salary and age on the effective date of the plan.

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. 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 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 MEMBER ____ **DATE** ________/________/________

Waiver of Group Insurance

Should I apply for waived coverage(s) in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, **at my own expense**. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

STOP! TWO SIGNATURES REQUIRED!

- Sign and date the application above
- Transfer total premium to 5.b. and answer 5.d.
- Sign the allotment form in 6.b. and date 6.b.

Make sure that you have an open allotment slot! Please review your paystub and look for “ALOT” entry. If there are more than two entries, you must cancel one allotment in order to enroll. Call Postalease to cancel an allotment.

PRIVACY ACT: The collection of this information is authorized by 39 USC 401, 1003 and 5 USC 8339. This information will be used to transfer your salary or portion thereof, to financial organizations for credit to your designated account. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes, where pertinent in a legal proceeding to which the USPS is a party or has an interest; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of UGPG finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity commission for investigation of a formal EEO complaint under 29 CFR1613 to the Merit Systems Protection Board or Office of Special Counsel for proceedings of Investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or State Agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647 to the National Association of Postal Supervisors that relates to postal supervisors; to the Office of Personnel Management, Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs, health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employee/annuitant data systems used to analyze Federal Retirement and insurance costs. Completion of this form is voluntary; however, if this information is not provided, your desires may not be met.

PART I – (Initiated by Member)

1. Member Name (As Shown on check)	2. Social Security Number
3. Home Address (No. and Street, Apt, City, State, ZIP +4)	4a. Postal Installation Where Employed (City, State, ZIP +4)
	4b. Finance Number

Complete Applicable Items Below

5a. REQUIRED Action (Check ONLY one)
☐ ESTABLISH a Net Check ☐ CHANGE a Net Check Financial Organization

5b. ESTABLISH an ALLOTMENT in the Amount of $	5c. CHANGE MY PRESENT ALLOTMENT From $ .00 To S .00

5d. Check (✓) This Item if You Have More Than One Allotment to a Financial Organization ☐

I certify that I am entitled to the payment identified above, and that I have read and understand the information printed above. In signing this form, I authorize my payment to be sent to the financial organization named below to be deposited to the designated account.

6a. Member (Signature)	6b. Date Signed	6c. Effective Date 10/10/2009

PART II – (Member to Complete Section 7c with Your USPS Member ID No.)

Financial Organization Certification

I confirm the identity of the above named payee(s) and the account number and title. As representative of the below named financial organization, I certify that the financial organization agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209 and 210. Pursuant to Treasury Department regulations, multiple deposits will not be made to a single common account, except for those joint accounts (such as husband and wife) in which the member's name(s) appear in the title.

7a. Financial Organization (Name, No. and Street, City, State, ZIP +4)	7b. Financial Organization Routing Number — Check digit 1 2 1 0 0 0 2 4 — 8
Wells Fargo Bank **Main Office** **420 Montgomery** **San Francisco CA 94104**	7c. Group Account Number to Be Credited (Up to 17 Positions) 8472UNMOO USPS Employee ID No.
	7d. Type of Account ☑ Savings ☐ Checking

Authorized by

8a. Name (Print or Type) Robert P. Callahan	8b. Title Assistant Vice President
8c. Signature [signature]	8d. Date Signed December 2008