Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

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

*Employer Name: Brown's Super Stores, Inc.		Effective Date:	Group ID: G000BGS3
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

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

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:			
*City:	*State:	*Zip Code:	

Dental Coverage Election

Employee and Dependent Coverage		
Dental - Employee Only	☐	$4.00
Dental - Employee + Family	☐	$9.00
	☐ Decline	

The following applies to Dental coverage:
- Your employer pays a portion of the premium for this coverage. The premium amounts above reflect your contribution.
- Your dependent child(ren) must be under age 26 to be eligible for insurance.

Dependent Information (If you enrolled dependents for insurance, you must complete this section. Please print clearly.)

If you need to list more dependents than space will allow, please include this information on a separate piece of paper and submit it with this form.

Name of Dependent Last name	First Name	Gender	Relationship to Employee	Birth Date (MM/DD/YYYY)

Enrollment Information

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

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 guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information
Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*
New Jersey Fraud Warning: Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

Dental Insurance

FOR EMPLOYEES OF BROWN'S SUPER STORES, INC.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 40 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	A child must meet the eligibility requirements of the Policy and be under age 26 if eligible as defined by Policy. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are shared by you and the policyholder. The premium amounts below reflect your contribution to the cost of this insurance.

LATE ENTRANT WAITING PERIODS	
Type A	None
Type B	12 Months
Type C	12 Months
Orthodontia	12 Months

PLAN YEAR DEDUCTIBLES AND MAXIMUMS	IN-NETWORK	OUT-NETWORK
Type A	Waived	Waived
Type B & C Deductible		
Individual	$50	$50
Family	3 times Individual	3 times Individual
Annual Maximum	$2,000	$2,000
Orthodontia Lifetime Maximum	$1,000	$1,000

The same expenses may be used to satisfy both the In-Network and Out-Network deductible.

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
Type A Services • Examinations/Evaluations • Bitewing X-rays • Fluoride Treatments • Cleaning/Prophylaxis • Sealants • Brush Biopsy/Cancer Screening	100%	80%

COVERED SERVICES	IN-NETWORK	OUT-NETWORK
Type B Services • Full Mouth X-rays, Panoramic Film • Space Maintainers • Palliative Treatment • Periodontal Maintenance • Fillings • Stainless Steel Crowns • Simple Extractions • Oral Surgery • General Anesthesia or I.V. Sedation • Endodontics • Periodontics	90%	80%
Type C Services • Full or Partial Removable Dentures • Repair of Full or Partial Removable Dentures • Adjustments, Tissue Conditioning, Rebasing or Relining of Full or Partial Removable Dentures • Bridges • Repair/Recementation of Bridges • Cast Crowns, Inlays, Onlays, Labial Veneers • Repair/Recementation of Cast Crowns/Inlays/Onlays/Labial Veneers	60%	50%
Child Orthodontia • Harmful Habit Appliances	60%	50%

1) The plan pays the percentage shown after the deductible is satisfied up to the maximum. Additional information about the benefits and covered services of this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or benefits administrator if you have questions prior to enrolling.
2) This plan provides different coverage levels for In-Network and Out-Network services. By using an In-Network provider, plan members will save more through the predetermined fee arrangement and better benefit coverage.
3) The Maximum Allowance for Out-Network Services is based on the 90th Percentile as determined by Mutual of Omaha. Charges that exceed the Maximum Allowance (as defined in the certificate booklet) for any covered dental service are not considered.

LIMITATIONS

Information about the limitations and exclusions for this plan will be included in the certificate booklet, which you will receive after enrolling for this coverage. Please contact your employer or Benefits Administrator if you have any questions prior to enrolling.

- Exams – Two services in a 12-month period.
- Bitewing X-rays – Four films in a 12-month period.
- Full Mouth X-rays or Panoramic Film – 1 in any 36-month period.
- Fluoride – For dependent children up to age 14. Two services in a 12-month period.
- Harmful Habit Appliance – For dependent children up to age 14.
- Cleaning/Prophylaxis – Two services in a 12-month period.
- Sealants – For dependent children up to age 14; one per permanent bicuspid or molar tooth in any 36-month period.
- Brush Biopsy/Cancer Screen – Two services in a 12-month period.
- Space Maintainers – For dependent children up to age 14, includes recementations and removal.
- Fillings – Composite fillings on molars are limited to the amount otherwise payable for an amalgam filling. Replacement once in a 12 month period.
- Stainless Steel Crowns – For dependent children up to age 16; one per tooth per lifetime. Not for temporary restoration.
- Periodontal Maintenance – Two services in a 12-month period in addition to routine cleaning. Following active periodontal treatment only.
- Orthodontia – Includes case workup, all appliances and one set of retainers. Braces/Appliances must be placed prior to the dependent child turning age 19 for orthodontic benefits to be payable.

SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 40 hours per week.

When does my coverage begin?

Complete enrollment information must be submitted to us through your Benefits Administrator *prior* to the requested effective date. Enrollment will be accepted within 31 days following the day you become eligible; however your effective date will then be the first of the following month.

When does my coverage begin for my dependents?

A Dependent child is considered eligible for insurance at birth and may be added to your policy at any time up to the child's third birthday. If we do not receive notification of the child's enrollment by age 3, you will be required to wait until the next Subsequent Enrollment Period to enroll the child.

Are there any waiting periods on this plan?

There is never a waiting period for Type A services. All insured persons will have these services available to them on the day they become effective.

Any employee who did not elect coverage when they were first eligible are considered 'late' to the plan at any other time they enroll. For these employees and family members, there is a 12 months waiting period for Type B, Type C and Orthodontic services.

If I enroll now, can I change or drop my coverage at any time?

Your enrollment in this coverage is for a 12 month Policy Year. During the Policy Year, you may drop coverage, or add or remove dependents, or terminate coverage within 31 days of a qualifying Life Change Event (as defined in the Certificate). These events include the birth of a child, pending adoption, marriage, divorce or loss of other coverage.