# Waiver of Participation in Non-Contributory Plan

Mutual of Omaha

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

| *Group/Policyholder Name: | *Group ID Number: G000 __ __ __ __ |
|---|---|

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

| *Last Name: | *First Name: | MI: |
|---|---|---|
| *Social Security Number: | *Birth Date (MM/DD/YYYY): | *Gender: | *Marital Status: |
| *Street Address: | E-mail Address: |
| *City: | *State: | *Zip Code: | Telephone: ( ) - |

**Waiver of Participation in Non-Contributory Plan of Insurance**

I am waiving my right to participate in the noncontributory plan of insurance offered to me by the Policyholder for the following: (CHECK ALL THAT APPLY)

☐ Group Term Life Insurance – Only for Amounts of Insurance in Excess of $50,000

☐ Group Term Life Insurance – All Amounts of Insurance

☐ Group Short-Term Disability Insurance

☐ Group Long-Term Disability Insurance

☐ Group Critical Illness Insurance

☐ Group Accident Insurance

☐ Group Accidental Death and Dismemberment Insurance

☐ Other: _____

I am waiving my right to participate in this plan/these plans:

☐ Due to religious/faith-based reasons

☐ To avoid possible federal and/or state income tax liability

☐ Other*: _____

*Any "Other" reason provided is subject to review and acceptance by Mutual of Omaha

**Agreement and Signature**

I understand that this waiver is not effective until it is received and recorded by Mutual of Omaha, and that this waiver shall be irrevocable for one full year from the date it is recorded by Mutual of Omaha. I further understand that evidence of insurability (medical underwriting) will be required, at my own expense, should I wish to reinstate this insurance in the future.

By signing below, I acknowledge that I understand and agree to the above statements. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

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

**Community Property Consent – To Be Completed by the Employee/Member's Spouse, If Applicable**

AZ, CA, ID, LA, NV, NM, TX, WA and WI are community property states. If you live in a community property state, state law may require that your spouse consent to any action you take with your insurance benefits. If you do not obtain your spouse's consent to this waiver of insurance, then this waiver may not be effective. Use of the term "spouse" on this form refers to the person to whom you are legally married, or your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in your jurisdiction of residence.

By signing below, I, _____ (INSERT YOUR FULL LEGAL NAME), do hereby consent to the foregoing waiver of insurance.

**SIGNATURE OF SPOUSE**_____ **DATE** _____