MUTUAL OF AMERICA
mutualofamerica.com

EMPLOYEE ENROLLMENT FORM
Group Life Insurance Plan

SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME First	Initial	Last

MAILING ADDRESS Street and Number *(Include Apartment Number)* City State Zip Code

IF FOREIGN RESIDENT	Province	Country	DATE OF BIRTH	
			/ /	☐ MALE ☐ FEMALE

EMPLOYER ONLY

EMPLOYER'S NAME			EMPLOYER NUMBER
DATE EMPLOYEE HIRED / /	PRIOR TAX-EXEMPT SERVICE If during the last three years this employee had service with another eligible organization that is to be counted toward meeting eligibility requirements, enter the number of months of such service that are to be counted.		NUMBER OF MONTHS
EMPLOYEE'S SALARY RATE $_____	EMPLOYEE'S DEPARTMENT # (IF APPLICABLE)	COVERAGE EFFECTIVE DATE Enter the coverage effective date.	DATE / /

BENEFICIARY DESIGNATIONS (Complete Reverse Side)

In the event of your death, the death benefit will be paid to the person or persons you name as your primary beneficiary. If no one you have named as a primary beneficiary survives you, the person(s) you name as your secondary beneficiary will receive the death benefit. If there is no living designated beneficiary at your death, the amount payable will be paid to the first surviving class of the following: (a) your surviving spouse (as determined under state law), (b) your surviving children in equal shares, (c) your surviving parents in equal shares, (d) your surviving brothers and sisters in equal shares, or (e) the executors or administrators of your estate.

If you name more than one primary beneficiary, or more than one secondary beneficiary, the death benefit will be paid in equal shares to the primary beneficiaries who survive you, or if none, to the secondary beneficiaries who survive you, unless you show below the percentage you want each of them to receive. If you specify percentages you want each beneficiary to receive, be sure your percentages for all beneficiaries in each beneficiary type total 100%.

Name your primary and secondary beneficiaries in the space provided on the reverse side. If you need more space, attach a page showing for each beneficiary the information asked for. Please add your Employer's name and Employer number, your signature and the date.

STATEMENT AND SIGNATURE

I understand that coverage will begin only when I have met the applicable eligibility requirements. My Employer has informed me of such eligibility requirements.

EMPLOYEE'S SIGNATURE	DATE

BENEFICIARY DESIGNATIONS

Beneficiary Type:
☒ Primary

Relationship:
☐ Spouse ☐ Child ☐ Parent ☐ Estate ☐ Other

FULL NAME First Initial Last		
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)	TELEPHONE NUMBER ( )
ADDRESS Street		
City	State	Zip Code
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %

Beneficiary Type:
☐ Primary ☐ Secondary

Relationship:
☐ Spouse ☐ Child ☐ Parent ☐ Estate ☐ Other

FULL NAME First Initial Last		
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)	TELEPHONE NUMBER ( )
ADDRESS Street		
City	State	Zip Code
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %

Beneficiary Type:
☐ Primary ☐ Secondary

Relationship:
☐ Spouse ☐ Child ☐ Parent ☐ Estate ☐ Other

FULL NAME First Initial Last		
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)	TELEPHONE NUMBER ( )
ADDRESS Street		
City	State	Zip Code
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %

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City	State	Zip Code
IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %

Beneficiary Type:
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Relationship:
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FULL NAME First Initial Last		
DATE OF BIRTH (Optional) / /	SOCIAL SECURITY # (Optional)	TELEPHONE NUMBER ( )
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IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %

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IF FOREIGN RESIDENT Province Country		BENEFIT PERCENT %