MUTUAL OF AMERICA
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EMPLOYEE ENROLLMENT FORM
Group Life Insurance (GLI)/Group Disability Income (GDI)

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, insert the number of months of such service that are to be counted.	NUMBER OF MONTHS

EMPLOYEE'S SALARY RATE	EMPLOYEE'S DEPARTMENT # (IF APPLICABLE)	ENTER THE COVERAGE EFFECTIVE DATES FOR THE RESPECTIVE PLANS:	GLI DATE / /	GDI DATE / /
$ _____				

BENEFICIARY DESIGNATIONS FOR GLI (Complete Reverse Side)

If you name more than one primary beneficiary, or more than one secondary beneficiary, the death benefit will be paid in equal shares unless you show on the reverse side the percentage you want each of them to receive. If you do this, be sure your figures for each beneficiary type total 100%.

If no one you have named as a primary beneficiary is living when the death benefit is to be paid, the person(s) you name as your secondary beneficiary will receive the death benefit. If no one you have named as a primary or secondary beneficiary is living at your death, the amount payable will be paid in the following order: to (a) your widow or widower, (b) your children in equal shares, (c) your parents in equal shares, (d) your brothers and sisters in equal shares, or (e) the executors or administrators of your estate.

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. I also understand that, if I am covered under the Group Disability Income Plan, payment of benefits is subject to any pre-existing conditions provision contained in the policy. My Employer has informed me of the eligibility requirements and of any such pre-existing conditions provisions.

EMPLOYEE'S SIGNATURE	DATE

BENEFICIARY DESIGNATIONS

Beneficiary Type:
[X] Primary
Relationship:
☐ Spouse ☐ Child ☐ Parent ☐ Estate ☐ Other

FULL NAME First Initial Last

DATE OF BIRTH / / | SOCIAL SECURITY #

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 / / | SOCIAL SECURITY #

ADDRESS Street

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

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