Use this form to add employee and/or dependents to coverage

GROUP INFORMATION

TO BE COMPLETED BY GROUP ADMINISTRATOR
Group Number_____ Effective Date _____ Subgroup_____ Class_____

IDAHO AGC HEALTH PLAN LARGE GROUP APPLICATION

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1 EMPLOYER/EMPLOYMENT INFORMATION

1. Name of Employer			2. Phone Number ( )
3. Address	4. City	5. State	6. Zip Code
7. Occupation	8. Hours Worked Per Week	9. Date You Started Work *(mm/dd/yyyy)*	

SECTION 2 APPLICANT INFORMATION (Employee)

1. **Legal** First Name, Middle Name, Last Name *(and suffix, if applicable)*				
2. Mailing Address *(Street, Route, P.O. Box)*				
3. City		4. State	5. Zip Code	6.County
7. Preferred **Daytime** Phone Number ( )	8. Email Address			9. Marital Status ❑ Single ❑ Married ❑Other
10.Gender ❑ Male ❑ Female	11. Social Security Number **(required)**			12. Date of Birth *(mm/dd/yyyy)*
13.Height	14.Weight			

If you wish to waive coverage for you and/or any dependents at this time, please complete Section 3 – Waiver of Coverage. If you wish to enroll yourself and/or your dependents, please complete all sections except Section 3.

SECTION 3 WAIVER OF COVERAGE *(To be completed only if coverage is declined or refused by an eligible employee or dependents.)*

1. I decline coverage for:

Self (name) _____ Dependent (name)_____

Spouse (name) _____ Dependent (name)_____

Dependent (name) _____ Dependent (name)_____

2. Reason for declining coverage (check all that apply):

❑ I and/or my dependents currently have other qualifying medical coverage with (name of carrier) _____ _____ through:

❑ My other employer ❑ My spouse's employer ❑ Individual policy ❑ Medicare ❑ Medicaid

❑ Tricare ❑ Indian Health Services **OR**

❑ Other reason for declining coverage (please explain): _____

SIGNATURE TO WAIVE**

I have decided to waive coverage as indicated above. I have been given the opportunity to apply for group coverage by the employer. Should I decide to apply for this coverage in the future, I realize and agree any coverage may be subject to additional probationary waiting periods.

****Signature** _____ **Date** _____

(sign only if waiving coverage) *mm/dd/yyyy*

Notice of enrollment rights: If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

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SECTION 4 ENROLLMENT INFORMATION (check all that apply)

1. Are you: ❑ A new applicant ❑ Adding dependents ❑ Enrolling during your employer's open enrollment
2. If you are enrolling ***outside*** of your employer's open enrollment or adding dependents, please mark the appropriate reason below and provide the date of the event (mm/dd/yyyy) _____
   (documentation may be required) ❑ Marriage ❑ Divorce ❑ Birth ❑ Adoption
   - ❑ Involuntary loss of ***employer*** coverage* ❑ Involuntary loss of ***individual*** coverage*
     *Provide name of carrier _____
   - ❑ Involuntary loss of Medicaid
   - ❑ Court order *(copy of court order required)* ❑ Other _____

3. Type of enrollment:

	HEALTH	DENTAL	VISION
Self Only	❑	❑	❑
Self and spouse	❑	❑	❑
Self, spouse & dependents	❑	❑	❑
Self & one dependent	❑	❑	❑
Self & two or more dependents	❑	❑	❑

4. Current employment status:
   ❑ Actively at work ❑ Retiree ❑ COBRA participant ❑ Disability ❑ Other

SECTION 5

DEPENDENT INFORMATION (List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy certification required). If you have more dependents to include, make a copy of this page and attach.)

Dependent's Name (first, initial, last)	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yyyy)	Height	Weight	Gender
Dependent 1						❑ Male ❑ Female
Dependent 2						❑ Male ❑ Female
Dependent 3						❑ Male ❑ Female
Dependent 4						❑ Male ❑ Female
Dependent 5						❑ Male ❑ Female
Dependent 6						❑ Male ❑ Female

SECTION 6

OTHER COVERAGE INFORMATION *(Please complete the section below if you have other coverage that will remain in effect. If you have more policies to include, make a copy of this page and attach.)*

Other Policy

1. Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number

2. Policy Holder Name

3. Names of Covered Members

4. Types of Coverage *(check all that apply)*
   ❑ Group ❑ Medical
   ❑ Individual ❑ Dental
   ❑ Medicare ❑ Vision

5. Coverage Start Date *mm/dd/yyyy*

6. Is this coverage terminating?
   ❑ Yes (complete #7)

7. Coverage End Date *mm/dd/yyyy*

8. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments?
   ❑ **No**
   ❑ **Yes** If yes, give person's name, type of Coverage, and reason for entitlement: _____ _____

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SECTION 7

HEALTH STATEMENT Skip all but number 10 on this page

(Complete this health statement if you apply for coverage for yourself or a family member after the original eligibility period.)

1. Have you or any family member listed on this application ever been advised to have any surgical operation(s) that you or any family member have not yet had?
   ❑ YES ❑ NO

2. Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted?
   ❑ YES ❑ NO

3. During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication?
   ❑ YES ❑ NO

4. Are you or any family member listed on this application now pregnant?
   ❑YES ❑ NO If pregnant, what is the anticipated delivery date?

5. Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?
   ❑ YES ❑ NO

6. Have you or any family member listed on this application been hospitalized during the last 5 years?
   ❑ YES ❑ NO

7. Within the past two years, have you or any member of your family been treated for back/joint disorder?
   ❑ YES ❑ NO

8. Have you or any family member listed on this application ever had, been told he or she had, been counseled or treated for any of the following: alcohol/drug use or abuse, cancer, heart problem/disorder, diabetes, digestive disorder, immune disorder, renal/kidney disease, strokes, mental or nervous disorders or respiratory disorders?
   ❑ YES ❑ NO

If you checked YES to any question above, please provide details below *(please use extra paper if necessary)*:

Item No.	Person Affected	Month/ Year	Name of Disease/ Symbom or Condition Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs Include Type or Name, Dosage, Strength and Duration	Name of Physician

9. Has any person listed on this application used a tobacco product on average four or more times a week within no longer than the past six months (anyone age 18 or older)? ❑ No ❑ Yes **If yes**, list names below:

_____ _____

_____ _____

10. Are you or any of your dependents listed on this application currently disabled? ❑ No❑ Yes

Name of disabled person _____ Physician's name and phone _____

Date of disability _____ Physician's address _____

Nature of disability _____

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SECTION 8 AFFIRMATION

I affirm the answers in this "Idaho AGC Health Plan Large Group Application" are complete and correct. I am providing these answers as part of the application procedure required by the Idaho AGC Health Plan to enroll in its coverage. I understand that the Idaho AGC Health Plan will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if I have made any misstatement or omission in this application, the Idaho AGC Health Plan may take any action available by law, including but not limited to, retroactive adjustment of contributions or claims. Further, I understand that any fraud or intentional misrepresentation of material fact on the part of the employer is cause for retroactive termination of coverage by the Idaho AGC Health Plan and/or other action available by law. I will promptly inform the Idaho AGC Health Plan in writing if anything happens before my coverage takes effect that makes an answer on this application incomplete or incorrect. Following receipt of a fully-executed application, coverage will be in force as of the effective date determined by the Idaho AGC Health Plan under applicable law.

SECTION 9 STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the Idaho AGC Health Plan, or of my employer, can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The Idaho AGC Health Plan may terminate or rescind an employer's group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the Idaho AGC Health Plan's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- As proof of status of employment, I authorize my employer to release to the Idaho AGC Health Plan appropriate documents, including but not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- Coverage for me and any eligible persons named on this application will begin on the effective date pursuant to the terms of the plan/ contract.
- I agree to abide by the terms of the group's master policy/member certificate, which sets forth all of the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the Idaho AGC Health Plan.
- I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.

SECTION 10 ACKNOWLEDGMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Employee _____ Date *(mm/dd/yyyy)* _____

Signature of Spouse _____ Date *(mm/dd/yyyy)* _____
(if applying for coverage)

FOR OFFICE USE ONLY Electronic System ID

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-018070-00 / Idaho AGC Health Benefit Plan.

Employer/Policyholder Name _____

Street Address _____ City _____ State _____ Zip Code _____

Employee Occupation/Job Title _____ Employee Date of Employment _____

☐ Full Time Employee ☐ Part Time Employee

Effective Date of Coverage _____

$_____/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Social Security Number _____

Reason for Enrolling _____

I. EMPLOYEE/ENROLLEE INFORMATION

Name _____ Sex ☐ M ☐ F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____ Marital Status _____

II. BENEFITS (Please check if you wish to enroll)

	Y	No	Indicate the benefit amount
Employee Life	X		$25,000 Flat Amount – Employer Paid
Employee AD&D	X		$25,000 Flat Amount – Employer Paid
Basic Spouse Life	X		$5,000 Flat Amount – Employer Paid
Basic Child Life	X		$5,000 Flat Amount – Employer Paid
Core Short-Term Disability Income Insurance	X		$125 Flat Amount – Employer Paid
*Employee Supplemental Life (Select one)			$25,000 or $50,000 or $75,000 or $100,000
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
**Spouse[2]			$ _____ (In $5,000 Increments)
Child[2]			$2,000 Flat Amount
Buy Up Short-Term Disability Income Insurance			
➢ Option 1			$325 Flat Amount includes Basic
➢ Option 2			$525 Flat Amount includes Basic

*New hires -> For Employee Supplemental Life, employee may elect in increment of $25,000 up to a maximum of $100,000 without evidence of insurability.

-> **For Dependent Spouse Supplemental Life coverage, employee may elect in increments of $5,000, up to a maximum of $50,000; not to exceed 50% of the Employee Supplemental Life benefit amount.

*During annual modified open enrollment –> For Employee Supplemental Life, employee may increase the current coverage by one increment without Evidence of Insurability.

->** For Dependent Spouse Supplemental Life coverage, employee may increase the current coverage by one increment without Evidence of Insurability

[2] ***List Dependents' names and birthdates (use another page if needed).***

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Mailing Address: Select Benefit Administrators
PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd Street East | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919

ACCIDENT BENEFIT

ENROLLMENT/CHANGE REQUEST
For Select Benefits Group Insurance

Group Information (To be Completed by Employer)

Idaho AGC

Group name	Effective date for action requested	Group number
		12306000

☐ Newly-Eligible Request ☐ Subsequent Enrollment Period ☐ Special Enrollment Request

Reason_____

Authorized Representative signature (required)	Date

Name (printed)	Title

Your Information (To be completed by individual requesting coverage)

Name	Social Security number

Date of birth	Date of hire	Gender	Home phone	Work phone
		☐ M ☐ F		

Job title / occupation	I am actively working	Average number of hours worked per week
	☐ Yes ☐ No	

Home address City State Zip

Email address	Marital Status
	☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Separated ☐ Widowed

Action Requested

- ☐ Enroll in the coverage for insurance as selected below.
- ☐ Change (add, increase, decrease, terminate) my current coverage, as shown below.
- ☐ Update information about me, my dependents and/or beneficiaries.
- ☐ Terminate all current coverage.

Coverage

Accident

Option $2,500 / 3 Occurences per year
Identify coverage option

- ☐ Self = $14.12
- ☐ Self plus spouse = $30.09
- ☐ Self plus child(ren) = $23.14
- ☐ Self plus family = $41.90
- ☐ Decline

Dependent Information *(Complete to add, change or terminate coverage for dependents. List additional dependents on a separate sheet and attach to this form.)*

No person can be insured under any policy as both a certificateholder and a dependent, or as a dependent of more than one certificateholder. The effective date of coverage for a dependent who is confined may be delayed.

Name

Date of birth	Gender ☐ M ☐ F	Full-time student ☐ Yes ☐ No	Relationship

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Name

Date of birth	Gender ☐ M ☐ F	Full-time student ☐ Yes ☐ No	Relationship

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Name

Date of birth	Gender ☐ M ☐ F	Full-time student ☐ Yes ☐ No	Relationship

Home address (if different than your address) City State Zip

☐ Add
☐ Change
☐ Terminate
Coverage: ☐ Accident

Signatures *(Sign and date **only one option** below. Retain a copy for yourself. Provide the original to your insured group's representative.)*

Authorization *(If you are enrolling in, changing or updating coverage)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy (or policies) insured by Symetra Life Insurance Company. I authorize the deduction from my earnings for any contribution I am required to make toward the cost of this insurance. I further understand that I may not be able to make any changes to my elected coverage until the next enrollment period.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

Waiver *(If you are declining or terminating all coverage.)*

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 30 days of the date I am first eligible, that I may have to wait to obtain coverage until the next enrollment period.

Further, I understand that I may not be able to obtain coverage for life insurance, disability, or critical illness benefits in the future without submitting satisfactory evidence of insurability to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

Reason: ☐ I already have insurance ☐ Other____________________________

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

SELECT BENEFITS

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

Accident Coverage

Help when the unexpected happens

Accidents can happen to anyone, at any time. Could you afford the financial hit if an accident happened to you or someone in your family? Select Benefits accident coverage can help with some of the costs after an accident, so you and your family can get the care you need and get back to your daily routine.

How it works

Select Benefits accident coverage provides benefits for **up to three accidents per covered person per calendar year**. That means **all eligible expenses associated with an accident are covered at 100%, up to the benefit limits**. Benefits are paid no matter what other coverage you may have, and you can visit any provider you like.

The first expense must be incurred within 60 days of the accident, with all remaining expenses incurred within 52 weeks of the accident.

Why accident coverage?

Understanding how accident coverage fits into your overall benefits package can help you decide if it's right for you and your family.

Consider your health care out-of-pocket liability. **Accident coverage can help close coverage gaps when there are deductible, copay or coinsurance requirements to meet.**

Accident coverage benefits can also be used to pay for additional costs triggered by an accident, such as child or elder care during recovery.

Turn the page to learn more

What's covered?

X-rays

Benefits are provided for eligible expenses incurred in connection with an accident when they are ordered or performed by a physician.

Inpatient prescription drugs

Benefits are provided for eligible expenses incurred in connection with an accident if the insured is confined in a hospital, and the drugs are prescribed by a physician and administered in the hospital by a licensed health care provider.

Surgery

Benefits are provided for eligible expenses incurred in connection with an accident when surgical procedures are performed by a licensed physician.

Dental

Benefits are provided for eligible expenses performed by a licensed physician or licensed dentist in connection with the following accidents:

- Dislocation of jaw
- Injury to natural teeth
- Closed or open reduction of a fracture

Medical

Benefits are provided for the following services and supplies when they are provided or prescribed by a licensed physician or other licensed health care provider in connection with an accident:

- Physician office visits
- Emergency room visits
- Outpatient hospital visits
- Urgent care visits
- Chiropractic visits
- Rehabilitation services
- Nursing services

Inpatient hospital

Benefits are provided for eligible expenses incurred in connection with an accident if all of the following conditions are met:

- The insured is confined in a hospital.
- A charge is made for room and board.
- The entire duration of the hospital confinement is recommended and approved by a physician.
- Confinement is the result of a non-occupational accident.
- The services and supplies used are not excluded under the exclusions and limitations provision of the policy.

DID YOU KNOW?

6 IN 10

LACK THE SAVINGS TO COVER A $500 EXPENSE[1]

Claims Example

Carlos and Angela both work at ABC, Inc. and knew that enrolling in their company's accident coverage was the right decision for their lifestyles. Carlos chose to cover himself and his family while Angela only needed coverage for herself. Here's how the year went for these two employees:

ABC, Inc. offers a Symetra accident plan that pays up to $2,500 per occurrence for up to three occurrences per person, per year.

Carlos and his family

One morning Carlos falls off a ladder while cleaning the gutters and hurts his back and head.

Emergency room: $720
X-ray: $510
MRI: $1,025
Physician fees: $300

Total expenses:
$2,555
Benefits paid:
$2,500
Out-of-pocket:
$55

While playing soccer, Carlos and his son Jason run into each other. Jason loses a tooth and Carlos sprains his ankle.

Carlos:
Doctor's office: $234
X-ray: $180
Physical therapy: $500

Total expenses:
$914
Benefits paid:
$914
Out-of-pocket:
$0

Jason:
Dental exam: $288
Dental implant surgery: $1,500

Total expenses:
$1,788
Benefits paid:
$1,788
Out-of-pocket:
$0

Angela

One evening, Angela crashes her bike and ends up cutting her knee and breaking her collarbone.

Urgent care: $200
Stitches: $1,250
X-ray: $115
Physician fees: $175

Total expenses:
$1,740
Benefits paid:
$1,740
Out-of-pocket:
$0

For illustrative purposes only.

Even though Carlos and Angela also enrolled in the ABC, Inc. major medical plan, they were able to use their Symetra accident coverage to help meet their deductible requirement.

Turn the page to learn more

Why enroll?

Let's face it, our lives are busy. Whether we're going straight from work to the grocery store or heading to after-school activities, we're not thinking about things taking unexpected turns. But if they do, Select Benefits accident coverage can help. By paying 100% of all eligible expenses up to the policy limit, these valuable benefits help allow you to focus on recovery after an accident, not your finances.

To learn more about how Select Benefits accident coverage can make a difference for you and your family, talk to your HR or benefits representative.

In addition to a lower group rate, enrolling in Symetra accident coverage through your employer also means:

- **Easy enrollment**
- **No medical questionnaires**
- **Convenient payroll deduction**

Get started

- ☑ Review your enrollment material.
- ☑ Follow the steps outlined by your benefits team.
- ☑ Complete the enrollment process.

Don't miss your opportunity to enroll in this valuable coverage at work. To get started, talk to your HR or benefits representative.

Enrollment starts soon.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

www.symetra.com
www.symetra.com/ny

Accident coverage is designed to pay benefits up to a preselected, per-occurrence amount for eligible expenses related to an accidental injury. It is not a replacement for a major medical policy or other comprehensive coverage and may be subject to exclusions, limitations, reductions and termination of benefit provisions. For costs and complete details of the coverage, contact your benefits representative.

Select Benefits accident coverage policies are insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. Policy form number is LGC-10011C 10/11 in most states. Not available in all U.S. states or any U.S. territory.

In New York, a Select Benefits accident coverage policy is insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124. Policy form number is LGC-10011C/NY 10/11.

Symetra Life Insurance Company is a direct subsidiary of Symetra Financial Corporation. First Symetra National Life Insurance Company of New York is a direct subsidiary of Symetra Life Insurance Company and is an indirect subsidiary of Symetra Financial Corporation (collectively, "Symetra"). Neither Symetra Financial Corporation nor Symetra Life Insurance Company solicits business in the state of New York and they are not authorized to do so. Each company is responsible for its own financial obligations.

[1] 6 in 10 Americans don't have $500 in savings: http://money.cnn.com/2017/01/12/pf/americans-lack-of-savings/index.html

Select Benefits Plan Design for
12306000 - The Idaho AGC

Group Accident

Group Accident Benefit	up to $2,500 per occurrence 3 occurrences per person, per calendar year maximum
Monthly Premium	
Employee	$14.12
Employee + Spouse	$30.09
Employee + Children	$23.14
Family	$41.90

Value-add benefits are included at no additional cost to you. These services are provided by Health Advocate, Inc., 3043 Walton Road, Suite 150, Plymouth Meeting, PA 19462. Please review the Value-add benefits flier for more information on these services. Not an insured benefit.

Description of Benefit

Group Accident Benefit
This benefit pays eligible expenses up to the benefit amount selected per accident occurrence. Expenses must be incurred within 52 weeks from the date of the accident with the first expense incurred within 60 days of the date of the accident.

Health Advocacy
Personalized assistance with a full range of health coverage and insurance-related issues such as locating doctors and other providers, scheduling appointments, getting cost estimates and more.

NurseLine™
Direct access to a registered nurse 24/7 for non-urgent concerns.

Medical Bill Saver™
Help negotiating with providers for medical and dental bills that are not covered by your insurance.

EAP+Work/Life
Licensed professional counselors and work/life specialists provide confidential, short-term help with personal, family and work-related issues.

Wellness Program
Unlimited access to highly trained wellness coaches by telephone, email or instant messaging. Includes a comprehensive, secure wellness website.

If there is any conflict between this information and the policy issued, the terms of the policy will prevail.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Group Life Insurance

Basic Life and Accidental Death & Dismemberment

SUMMARY OF BENEFITS

Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	**Life Benefit**
Amount	$25,000
Minimum Amount	$25,000
Maximum Amount	$25,000
Guarantee Issue	$25,000

Employee	**AD&D Benefit**
Amount	$25,000
Minimum Amount	$25,000
Maximum Amount	$25,000

Spouse	**Dependent Life Benefit**
Spouse Amount	$5,000
Maximum Amount	$5,000
Guarantee Issue	$5,000

Child	**Dependent Life Benefit**
Child Amount	15 day(s) to 26 year(s): $5,000

Benefit Reduction	**Employee's Age**
Current Benefit Amount Reduced By	35% at age 70 15% at age 75 20% at age 80

Benefit Reduction	**Spouse's Age**
	Benefits Terminate at Age 70

Eligibility	
	All active full-time employees eligible for medical coverage working a minimum of 30 hours per week and their eligible dependents.

Additional Benefit Details	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care, Rehabilitation, Spouse Education, Adaptive Home and Vehicle, Critical Burn, Therapeutic Counseling, Felonious Assault and Coma benefits. Please refer to your employee certificate for additional information.

Value Added Services	
Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Disability Insurance **Short Term Disability**

SUMMARY OF BENEFITS Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefit Amount	$125 per week
Minimum Benefit Amount	$15
Maximum Payment Duration	13 weeks
Elimination Period	Accident - 14 days Sickness - 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan and working a minimum of 30 hours per week.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Disability Insurance **Short Term Disability**

SUMMARY OF BENEFITS Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefits:	
Core plan	$125 per week
Buy-up plan	Additional $200 per week
Minimum Benefit Amount	$15
Maximum Payment Duration	13 weeks
Elimination Period	Accident - 14 days Sickness - 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of $26,000 or more Annually and electing the $200 Buy Up working a minimum of 30 hours per week.

New Hire: Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.

Late Entrant: You will need to provide Evidence of Insurability if you apply for coverage more than 31 days after the date you are first eligible to apply.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Costs for Buy Up Short Term Disability coverage

Monthly costs:

AGE	Monthly Cost
Under 45	$3.20
45 - 49	$4.10
50 - 54	$4.78
55 - 59	$5.80
60 and over	$7.00

Insured by Symetra Life Insurance Company

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Group Disability Insurance **Buy Up Short Term Disability**

SUMMARY OF BENEFITS Class 2

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Benefit Highlights:

Benefits:	
Core plan	$125 per week
Buy-up plan	Additional $400 per week
Minimum Benefit Amount	$15
Maximum Payment Duration	13 weeks
Elimination Period	Accident - 14 days Sickness - 14 days (number of days you must be disabled to collect disability benefits)
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Eligibility

All Full-Time Employees Participating in the Idaho AGC Sponsored Medical Plan earning a minimum of $43,333 or more Annually and electing the $400 Buy Up working a minimum of 30 hours per week.

New Hire: Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.

Late Entrant: You will need to provide Evidence of Insurability if you apply for coverage more than 31 days after the date you are first eligible to apply.

Standard Provisions:

- Maternity is covered the same as any other condition.
- Non Occupational
- 14 days recurrent disability/temporary recovery

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Cost for Buy Up Short Term Disability coverage

Monthly cost:

AGE	Monthly Cost
Under 40	$8.80
40 - 44	$9.20
45 - 49	$11.60
50 - 54	$14.00
55 - 59	$17.20
60 and over	$20.00

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Life Insurance — Supplemental Life

SUMMARY OF BENEFITS — Class 1

Sponsored By: **Idaho AGC Health Benefit Plan**
Effective Date: **January 1, 2020**
Policy Number: **01-018070-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Employee	**Life Benefit**
Amount	Increments of $25,000
Minimum Amount	$25,000
Maximum Amount	$100,000
Guarantee Issue	$100,000

Spouse	**Life Benefit**
Spouse Amount	Increments of $5,000
Minimum Amount	$5,000
Maximum Amount	$50,000 not to exceed 50% of Supplemental Employee Coverage
Guarantee Issue	$50,000

Child	**Life Benefit**
Child Amount	15 day(s) to 26 year(s): $2,000

Benefit Reduction	**Employee**
No Reductions	

Benefit Reduction	**Spouse**
	Benefits Terminate at Age 70

Eligibility

All active full-time employees eligible for medical coverage working a minimum of 30 hours per week and their eligible dependents.

Evidence of Insurability	
New Hires:	Enroll within 31 days after becoming eligible under The Policy without Evidence of insurability.
Annual Enrollment:	During annual enrollment, employee may enroll or elect one increment of $25,000 for employee and one increment of $5,000 for spouse without Evidence of Insurability. Evidence of Insurability is required for any election during annual enrollment over one increment of $25,000 for employee and one increment of $5,000 for spouse.

Additional Benefit Details	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for an employee that becomes disabled. Certain restrictions apply. Please refer to your employee certificate for additional information.

Contact Information for Claims

Phone: 1-877-377-6773
Fax: 1-877-737-3650

Symetra Life Insurance Company
Life and Absence Management Center
P.O. Box 1230
Enfield, CT 06083-1230

Rates for Supplemental Life coverage

Monthly Employee and Spouse* Supplemental Life Rates per $1,000 of coverage

AGE	RATE
Under 25	$0.067
25 - 29	$0.070
30 - 34	$0.094
35 - 39	$0.119
40 - 44	$0.142
45 - 49	$0.211
50 - 54	$0.351
55 - 59	$0.625
60 - 64	$0.878
65 - 69	$1.616
70 - 74	$2.617
75 - 100	$2.617

***Supplemental Spouse Life Rates are based on Spouse's Age**

Monthly Child Supplemental Life Rate per Family Unit of coverage is $0.40

Calculating Your Cost

Supplemental Employee Life:	_____ (volume)	x	_____ (rate)	/1,000 =	$ _____	Monthly Cost
Supplemental Spouse Life:	_____ (volume)	x	_____ (rate)	/1,000 =	$ _____	Monthly Cost

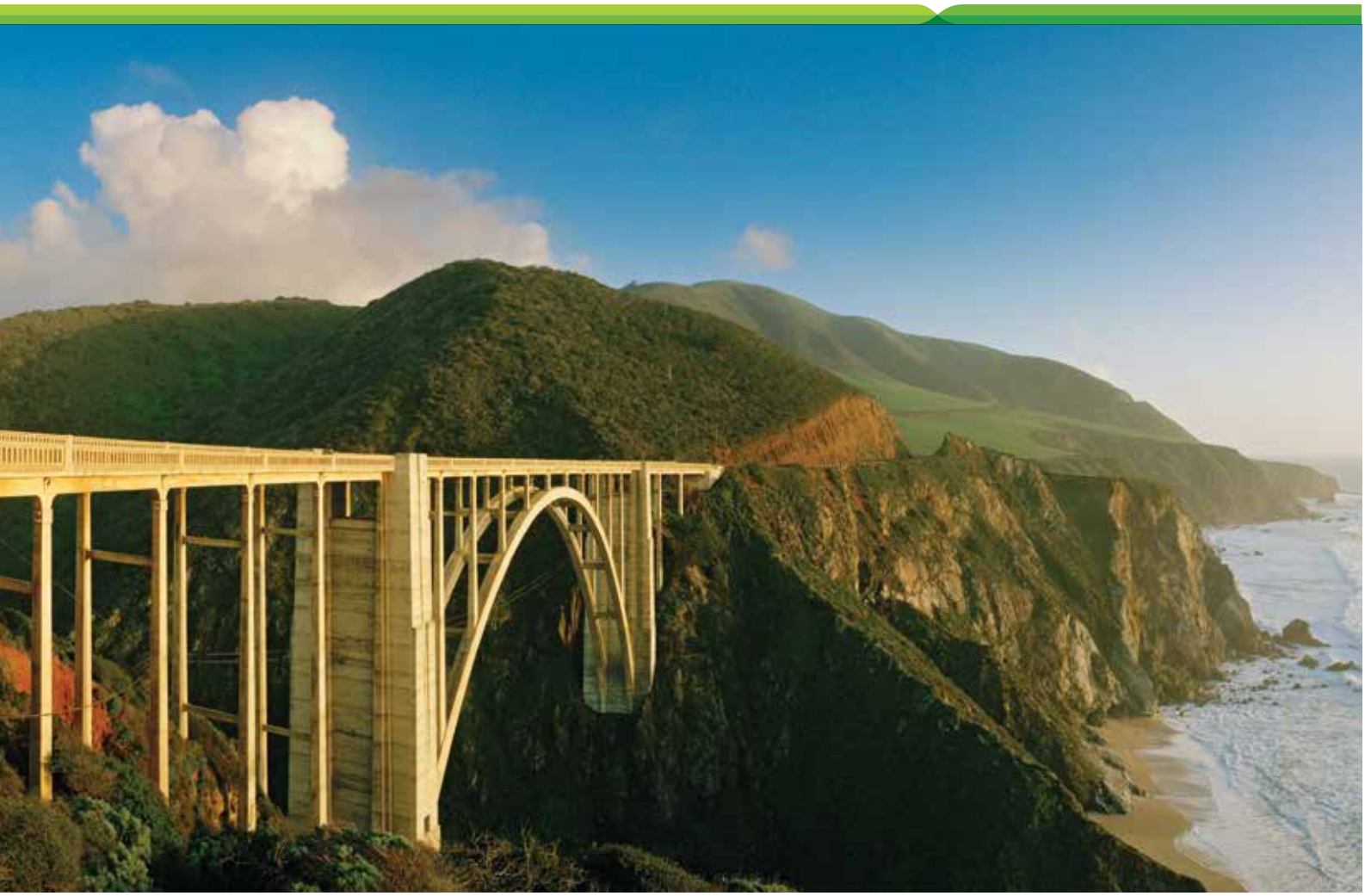
This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-018070-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

SYMETRA®
RETIREMENT | BENEFITS | LIFE

A network of support

Value-Add Programs for Group Life and Disability Income Insurance



Support for life's changes

We can't predict where life is going to take us. An injury or illness could send an otherwise active person out on disability leave for an indefinite period of time. Or the loss of a loved one may leave a family struggling to cope with the emotional and financial stress of rebuilding their lives.

That's when employees truly appreciate the network of professional support offered with **Group Life and Disability Income Insurance** from Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York. Our value-add programs complement the insurance benefits provided under each policy and strengthen our goal of getting people to a better place.

Employee Assistance Program (EAP) with Will Preparation

Finds the resources employees need to help with a variety of issues such as finding child or elder care, managing a serious illness or dealing with work/life issues.

Health Care Navigation

Encourages employees on a covered disability leave to become educated, engaged consumers in their health care.

Travel Assistance

Provides support when employees are traveling 100 miles or more away from home.

Identity Theft Protection Program

Helps protect employees from ID theft while providing support in the event their identity is stolen.

Beneficiary Companion

Offers a helping hand for families after a loss.

Employee Assistance Program (EAP)

It's tough for employees to do their best at work when faced with challenges such as finding child or elder care, dealing with substance abuse or managing family relationships. That's where an EAP can help.

Program Highlights

Five confidential face-to-face sessions[1]
Enrolled employees and their household family members are eligible for up to five confidential sessions with a counselor, financial planner or lawyer each calendar year.

- Consultations may be face-to-face or by phone
- Sessions are per household and may be divided between the three types of professionals
- Counselors provide an assessment of concerns and refer participants to appropriate resources and providers
- Financial and legal professionals assist with matters such as tax-filing questions, debt issues, guardianship and power of attorney
- An additional five sessions are available in the event of a covered disability claim

Will preparation
EAP also includes will preparation services via the "Featured Programs" section of www.guidanceresources.com. Employees can create a simple, legally binding will for just $14.99; printing and mailing services are available for an additional fee. Prices may be subject to change—contact ComPsych for additional information.

Who's Eligible?

DisabilityGuidance® (provided by ComPsych®) is available to anyone covered by a Symetra Group Disability Income Insurance policy at no additional employer cost.

For more information on the full service GuidanceResources® EAP option, which provides valuable tools for HR representatives and managers, contact your Symetra representative.

Accessing Services

Employees can call toll-free **1-888-327-9573**. The website, **www.guidanceresources.com.** provides access to self-assessment tools; tailored searches for child and elder care, attorneys and CPAs; and other helpful services. **Use SYMETRA in the Organization Web ID field to log in.**

[1] In California, counseling sessions are limited to three sessions in a six-month period.

Health Care Navigation

Employees generally find themselves on their own when it comes to dealing with their medical plan. They're eager to find resources that can reassure them they are making the best decisions—a partner who can help navigate through their medical plan benefits.

Administrative Support

- Easy-to-understand explanation of benefits—help identifying what's covered and what's not
- Step-by-step guidance on medical claims and billing issues
- Cost estimation for covered and/or non-covered treatment options
- Fee and payment plan negotiation
- Referral to financial resources for the underinsured and uninsured
- Explanation of the appeals process

Clinical Support

- One-on-one reviews of employee health concerns
- Straightforward, easy-to-understand answers regarding specific diagnosis and treatment options
- Support and preparation for upcoming doctor's visits, lab work, tests and surgeries
- Coordination with appropriate health care plan provider(s)
- Referral to community resources and applicable support groups

Administrative and clinical specialists may also refer employees to DisabilityGuidance® EAP services and other work/life resources.

Who's Eligible?

HealthChampion℠ (provided by ComPsych) is available for employees on a covered short- or long-term disability leave.

For more information on buy-up programs including options that offer HealthChampion to all employees, regardless of disability claim status, contact your Symetra representative.

Accessing Services

Claimants can call **1-866-263-4365** to access the health care navigation program 24 hours a day, seven days a week.

Assistance While Traveling

The Travel Assistance Program is available 24 hours a day to help protect employees, their spouses and dependent children from the unpredictable, whenever they travel 100 miles or more from home for less than 90 consecutive days.*

Key Services

- Help finding physicians, dentists and medical facilities
- Medical monitoring to determine if care is appropriate
- Transportation to a hospital/treatment facility or return home for treatment
- Arrangement for a dependent or traveling companion's return home
- Replacement of medication and eyeglasses
- Emergency message relay to and from friends, relatives and business associates
- Emergency cash
- Assistance locating lost or stolen items
- Legal assistance/bail
- Interpretation/translation services

Additionally, participants can call anytime and from anywhere to get pre-trip information or ask questions.

Who's Eligible?

Travel Assistance (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Employees just pick up the phone—24 hours a day, seven days a week—and call **1-877-823-5807** from North America or **(240) 330-1422** from anywhere else in the world.

*Students are covered for longer.

Identity Theft Protection Program

Identity theft is a rising concern. The Symetra Identity Protection Program provides employees with information to protect themselves and step-by-step coaching to help identify and resolve identity theft.[1]

Key Services

- Lost wallet assistance[2]
- Credit information review[3]
- 3-bureau fraud alert placement assistance
- ID theft affidavit assistance
- Translation services while traveling
- Emergency cash advance while traveling (a repayment guarantee is needed)

A comprehensive Identity Theft Resolution Kit will provide employees with information and includes documentation and details about how to tackle the problem if their identity has been compromised.

Who's Eligible?

Identity Theft Protection (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Employees can call anytime, from anywhere—24 hours a day, seven days a week. The number for North America is **1-877-823-5807** and those traveling anywhere else in the world can call **(240) 330-1422.**

[1] Identity thefts discovered prior to enrollment in Symetra Group Insurance are not eligible for services.

[2] Europ Assistance will assist you with cancelling lost credit cards and provide information to help you replace lost items such as your driver's license and Social Security card.

[3] Member must provide a copy of their credit report which can be obtained free of charge at www.annualcreditreport.com (once every 12 months).

A Helping Hand for Beneficiaries

The Beneficiary Companion Program is there to help with paperwork and other time-consuming details, providing relief from the confusion and frustration of managing a loved one's final affairs.

Key Services

- Guidance on how to obtain death certificate copies for final notifications
- Dedicated Beneficiary Assistance Coordinators to manage notifications and close loved one's accounts, including:

  Social Security Administration

  Credit reporting agencies

  Credit card companies/financial institutions

  Third-party vendors

  Government agencies

- Assistance protecting the loved one's identity and full resolution services in case the deceased's identity is stolen

Who's Eligible?

Beneficiary Companion (provided by Europ Assistance) is available to individuals covered by Symetra Group Life and/or Disability Income Insurance policies.

For more information and plan design requirements, contact your Symetra representative.

Accessing Services

Beneficiaries can call the Symetra-dedicated toll-free number at **1-877-823-5807** for 24/7 support.

About Symetra

Symetra is a financially strong, well-capitalized company on the rise, as symbolized by our brand icon—the swift. Swifts are quick, hardworking and nimble—everything we aspire to be when serving our customers. We've been in business for more than half a century, operating on a foundation of financial stability, integrity and transparency. Our commitment is to create employee benefits products that people need and understand.

To learn more about us, visit www.symetra.com, www.symetra.com/ny or contact your representative.

About ComPsych

ComPsych is the largest provider of employee assistance programs, managed behavioral health, work/life and crisis intervention services.

About Europ Assistance

As the inventor of the assistance concept in 1963, Europ Assistance has handled more than 225 million cases in their company history.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

www.symetra.com
www.symetra.com/ny