



**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
<b>Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.</b>			
Dependent Supplemental Life			\$ _____ (In \$5,000 Increments)
**Spouse <sup>2</sup>			\$2,000 Flat Amount
Child <sup>2</sup>			
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

<sup>2</sup> 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
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> 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.

## 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
<input type="checkbox"/> Newly-Eligible Request <input type="checkbox"/> Subsequent Enrollment Period <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Home phone	Work phone
Job title / occupation		I am actively working <input type="checkbox"/> Yes <input type="checkbox"/> No	Average number of hours worked per week	
Home address		City	State	Zip
Email address		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> 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 \_\_\_\_\_  
Identify coverage option

- Self
- Self plus spouse
- Self plus child(ren)
- Self plus family
- 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 <input type="checkbox"/> M <input type="checkbox"/> F	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
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Home address (if different than your address) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Add } **Coverage:**  Accident  
 Change }  
 Terminate }

Name \_\_\_\_\_

Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
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Home address (if different than your address) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Add } **Coverage:**  Accident  
 Change }  
 Terminate }

Name \_\_\_\_\_

Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship
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Home address (if different than your address) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Add } **Coverage:**  Accident  
 Change }  
 Terminate }

**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
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**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
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# Evidence of Insurability for Group Coverage Applicants Residing in Idaho

## Instructions

### Employer/Policyholder

Please complete Page 2 and provide to the employee/applicant to complete.

### Employee/Applicant

Please complete page 3, sign and date page 4 and an "Authorization for Release of Medical Information" form. If applying for spouse coverage, have your spouse complete page 6, sign and date page 7 and an "Authorization for Release of Medical Information" form. Return to Symetra for processing.

Two copies of the 'Authorization for Release of Medical Information' form are included in the back of this packet. One for you and one for your spouse, if applicable.

Completed forms can be mailed or faxed to:  
Symetra Life Insurance Company  
PO Box 34690  
Seattle, WA 98124-1690

Fax: 1-866-348-0058

Comments

## EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

**Policyholders: Completely fill out Sections 1 – 3 and forward to the applicant to complete, sign and return to Symetra.**

### Section 1: Group Plan Details *(to be completed by Policyholder)*

Company name (policyholder)	Policy number
Division or associated company (if applicable)	
Company mailing address (street, city, state, zip code)	
Benefits contact name (first, last)	
Benefits contact email address	Benefits contact phone (include area code)

### Section 2: Applicant Details *(to be completed by Policyholder)*

Name of applicant	Date of hire (mm/dd/yyyy)
Class	Basic Annual Earnings*

\*As described in the group policy

### Section 3: Coverages Requested *(to be completed by Policyholder)*      **Check all that apply**

Coverage (Check all that apply)	Current amount of coverage (including GI** amount)	Additional coverage requested	Total coverage amount
(Example for Life Policies)	\$25,000	\$100,000	\$125,000
<input type="checkbox"/> Applicant: Basic Life			
<input type="checkbox"/> Applicant: Supplemental or Voluntary Life			
<input type="checkbox"/> Spouse: Basic Life			
<input type="checkbox"/> Spouse: Supplemental or Voluntary Life			
<input type="checkbox"/> Child: Basic Life			
<input type="checkbox"/> Child: Supplemental or Voluntary Life			
<input type="checkbox"/> Applicant: Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Voluntary Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Applicant: Voluntary Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		

\*\*Guarantee Issue (GI) is the maximum amount of coverage defined by the group policy that does not require evidence of insurability.

**Section 4: Applicant Information** *(to be completed by applicant)*

Applicant name (first, last)					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Applicant address (street, city, state, zip code)						
Date of birth	Height	Weight	Driver License number		Email address	
State of birth		Day phone (include area code)		Evening phone (include area code)		
How may we best contact you? Symetra offers secure e-mail for the quickest turnaround time <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Day phone <input type="checkbox"/> Evening phone						
Full name, address and phone of your personal physician						

**Section 5: Applicant Health Information** *(to be completed by applicant)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant?  Yes  No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**

a) <input type="checkbox"/> Heart Disease or Disorder b) <input type="checkbox"/> Bipolar Disorder, Major Depressive Disorder, or Schizophrenia c) <input type="checkbox"/> Alcoholism and/or Drug Use d) <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)	e) <input type="checkbox"/> Stroke, Paralysis f) <input type="checkbox"/> Multiple Sclerosis, ALS (Lou Gehrig's Disease) g) <input type="checkbox"/> Type I/Insulin-Dependent Diabetes h) <input type="checkbox"/> Grand Mal Epilepsy or Generalized Seizures i) <input type="checkbox"/> Hepatitis B or C j) <input type="checkbox"/> Cirrhosis of the liver
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3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**

k) <input type="checkbox"/> Non-Insulin Dependent/ Type II Diabetes l) <input type="checkbox"/> Mental & Nervous Disorder; Depression/Anxiety m) <input type="checkbox"/> Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy n) <input type="checkbox"/> Liver Disorder o) <input type="checkbox"/> Kidney Disorder	p) <input type="checkbox"/> Blood Disorder q) <input type="checkbox"/> Stomach, Abdominal, Intestinal Disorder r) <input type="checkbox"/> Bone, Joint, Connective Tissue Disorder s) <input type="checkbox"/> Cancer, Tumors t) <input type="checkbox"/> Gland Disorder u) <input type="checkbox"/> Lungs, Respiratory Disorder
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4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above?  Yes  No  
**If yes, please indicate condition and provide details in the Health Information Section.**

**Section 6: Applicant Health Information** *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset		Duration	Degree of recovery	Name/address/phone of attending physician
		Mo.	Yr.			

**Please list all your medications**

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset	
			Mo.	Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of applicant	Date
Print name	

**Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.**

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**Applicant's copy**

**Disclosure Notice to Applicants for Insurance**

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

**Sources of Information:**

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

**Disclosure to Others:**

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

**Disclosure to You:**

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.\*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

*\*For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

**Please read the following notice that we are required by law to give to you.**

**For all states not named:** Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**AL:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**AR, LA, RI, WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CA:** For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**DE:** Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DC:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NH:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NJ:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NY:** The following applies to health insurance only: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PA:** 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.

**TN, VA, WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**TX:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Section 7: Spouse or Domestic Partner or Civil Union Partner Information***(to be completed by the Spouse or Domestic Partner or Civil Union Partner (if applicable))*

Spouse/Domestic Partner name (first, last)					Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (street, city, state, zip code)						
Date of birth	Height	Weight	Drivers license number		Email address	
State of birth		Day phone (include area code)		Evening phone (include area code)		
How may we best contact you? Symetra offers secure e-mail for the quickest turnaround time <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Day phone <input type="checkbox"/> Evening phone						
Full name, address and phone of your personal physician						

**Section 8: Spouse or Domestic Partner or Civil Union Partner Health Information** *(to be completed by the applicable person)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant?  Yes  No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

a) <input type="checkbox"/> Heart Disease or Disorder b) <input type="checkbox"/> Bipolar Disorder, Major Depressive Disorder, or Schizophrenia c) <input type="checkbox"/> Alcoholism and/or Drug Use d) <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)	e) <input type="checkbox"/> Stroke, Paralysis f) <input type="checkbox"/> Multiple Sclerosis, ALS (Lou Gehrig's Disease) g) <input type="checkbox"/> Type I/Insulin-Dependent Diabetes h) <input type="checkbox"/> Grand Mal Epilepsy or Generalized Seizures i) <input type="checkbox"/> Hepatitis B or C j) <input type="checkbox"/> Cirrhosis of the liver
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3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

k) <input type="checkbox"/> Non-Insulin Dependent/ Type II Diabetes l) <input type="checkbox"/> Mental & Nervous Disorder; Depression/Anxiety m) <input type="checkbox"/> Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy n) <input type="checkbox"/> Liver Disorder o) <input type="checkbox"/> Kidney Disorder	p) <input type="checkbox"/> Blood Disorder q) <input type="checkbox"/> Stomach, Abdominal, Intestinal Disorder r) <input type="checkbox"/> Bone, Joint, Connective Tissue Disorder s) <input type="checkbox"/> Cancer, Tumors t) <input type="checkbox"/> Gland Disorder u) <input type="checkbox"/> Lungs, Respiratory Disorder
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4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above?  Yes  No  
**If yes, please indicate condition and provide details in the Health Information Section.**

**Section 9: Spouse/Domestic Partner/Civil Union Partner Health Information** *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset		Duration	Degree of recovery	Name/address/phone of attending physician
		Mo.	Yr.			

**Please list all your medications**

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset	
			Mo.	Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of Spouse/Domestic Partner (if applicable)	Date
Print name	

**Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.**

**Applicant's copy**

**Disclosure Notice to Applicants for Insurance**

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

**Sources of Information:**

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

**Disclosure to Others:**

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

**Disclosure to You:**

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.\*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

*\*For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

**Please read the following notice that we are required by law to give to you.**

**For all states not named:** Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**AL:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**AR, LA, RI, WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CA:** For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**DE:** Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**DC:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NH:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NJ:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NY:** The following applies to health insurance only: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PA:** 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.

**TN, VA, WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**TX:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

*Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.*

## SYMETRA LIFE INSURANCE COMPANY

### Authorization for Release of Medical Information

---

Group Life Policy Number: \_\_\_\_\_

Name of insured/patient (please type or print): \_\_\_\_\_ Date of birth: \_\_\_\_\_

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may:

- 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage;
- 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

\_\_\_\_\_  
Signature of Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Patient

*Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.*

## SYMETRA LIFE INSURANCE COMPANY

### Authorization for Release of Medical Information

---

Group Life Policy Number: \_\_\_\_\_

Name of insured/patient (please type or print): \_\_\_\_\_ Date of birth: \_\_\_\_\_

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may:

- 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage;
- 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

\_\_\_\_\_  
Signature of Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Patient

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<sup>1</sup>

## 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.

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

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

<b>Carlos:</b>	<b>Jason:</b>
<b>Doctor's office:</b> \$234	<b>Dental exam:</b> \$288
<b>X-ray:</b> \$180	<b>Dental implant surgery:</b> \$1,500
<b>Physical therapy:</b> \$500	

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

<b>Total expenses:</b> \$914	<b>Total expenses:</b> \$1,788
<b>Benefits paid:</b> \$914	<b>Benefits paid:</b> \$1,788
<b>Out-of-pocket:</b> \$0	<b>Out-of-pocket:</b> \$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.**



[www.symetra.com](http://www.symetra.com)  
[www.symetra.com/ny](http://www.symetra.com/ny)

Symetra® is a registered service mark of Symetra Life Insurance Company.

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.

<sup>1</sup> 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

<b>Group Accident Benefit</b>	up to \$2,500 per occurrence 3 occurrences per person, per calendar year maximum
<b>Monthly Premium</b>	
<i>Employee</i>	\$14.12
<i>Employee + Spouse</i>	\$30.09
<i>Employee + Children</i>	\$23.14
<i>Family</i>	\$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.

Select Benefits insurance policies are not a replacement for a major medical policy or other comprehensive coverage and do not satisfy the minimum essential coverage requirements of the Affordable Care Act. They are designed to provide benefits at a preselected, fixed-dollar amount. Coverage may be subject to exclusions, limitations, reductions, and termination of benefit provisions. Select Benefits policies are insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004, and are not available in all U.S. states or any U.S. territory. Coverage is provided under generic policy form numbers SBC-00500, SBC-00535, and LGC-10011 or LGC-9072.



**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	35% at age 70
Amount Reduced By	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

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Symetra® is a registered service mark of Symetra Life Insurance Company.

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

Symetra® is a registered service mark of Symetra Life Insurance Company.

## 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**

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Symetra® is a registered service mark of 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:

<b>AGE</b>	<b>Monthly Cost</b>
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.

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Symetra® is a registered service mark of Symetra Life Insurance Company.



## 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:

<b>AGE</b>	<b>Monthly Cost</b>
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

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Symetra® is a registered service mark of 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

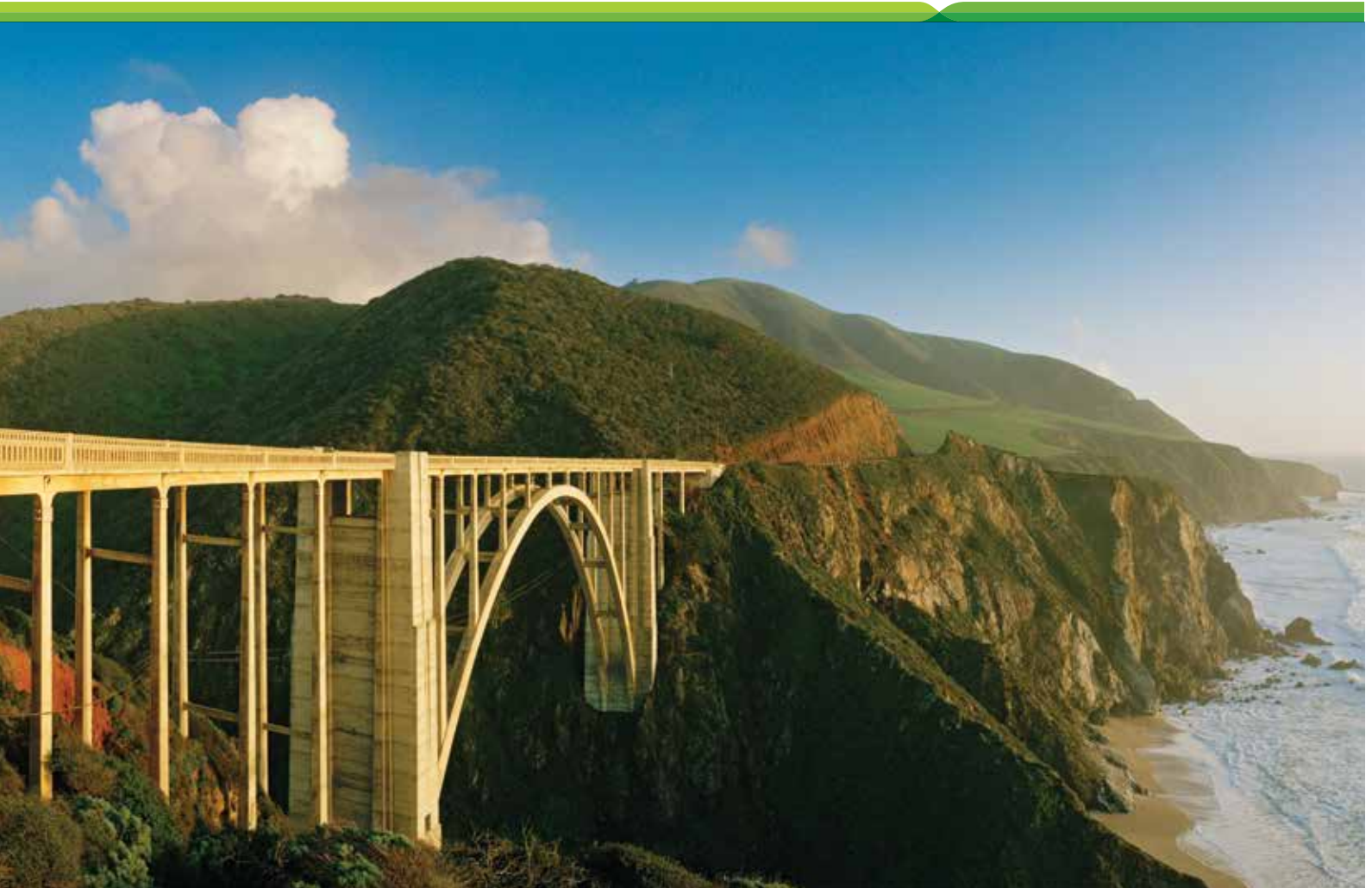
Supplemental Employee Life:	$\frac{\quad}{\text{(volume)}}$	x	$\frac{\quad}{\text{(rate)}}$	/1,000 =	$\frac{\$}{\text{Monthly Cost}}$
Supplemental Spouse Life:	$\frac{\quad}{\text{(volume)}}$	x	$\frac{\quad}{\text{(rate)}}$	/1,000 =	$\frac{\$}{\text{Monthly Cost}}$

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**

# 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.

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## > **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.

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## > **Health Care Navigation**

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

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## > **Travel Assistance**

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

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## > **Identity Theft Protection Program**

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

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## > **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<sup>1</sup>

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](http://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](http://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.**

<sup>1</sup> 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<sup>SM</sup> (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.<sup>1</sup>

## Key Services

- Lost wallet assistance<sup>2</sup>
- Credit information review<sup>3</sup>
- 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**.

<sup>1</sup> Identity thefts discovered prior to enrollment in Symetra Group Insurance are not eligible for services.

<sup>2</sup> 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.

<sup>3</sup> Member must provide a copy of their credit report which can be obtained free of charge at [www.annualcreditreport.com](http://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](http://www.symetra.com), [www.symetra.com/ny](http://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.



[www.symetra.com](http://www.symetra.com)  
[www.symetra.com/ny](http://www.symetra.com/ny)

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Group insurance policies are insured by and absence management programs are provided by Symetra Life Insurance Company, 777 108th Ave NE, Suite 1200, Bellevue, WA 98004 and are not available in any U.S. territory.

In New York, group insurance policies are insured by and absence management programs are provided by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124. Value-add programs are not available with New York group term life insurance coverage.

Coverage may be subject to exclusions, limitations, reductions and termination of benefit provisions.

EAP, Will Preparation and Health Care Navigation are offered by ComPsych® Corporation through Symetra Financial Corporation subsidiaries. Benefits may not be available in all states. Travel Assistance, Identity Theft Protection and Beneficiary Companion programs are offered by Europ Assistance through Symetra Financial Corporation subsidiaries. Benefits may not be available in all states. ComPsych Corporation and Europ Assistance are not affiliated with any of the subsidiaries under Symetra Financial Corporation.