SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
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GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-018070-00

Employer/Policyholder Name Idaho AGC Health Benefit Plan.

1649 W. Shoreline Drive, Suite 100 | Boise | ID | 83702
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

Class Number (if applicable)

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.