Idaho AGC HEALTH PLAN

Employee's Waiver of Health Care Coverage

If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date or experience a qualifying event.**

I certify that I have been informed of the availability of coverage under my employer's health benefit plan, but I choose not to enroll *(please check all that apply and list each eligible family member's name*):

☐ myself _____ ☐ my eligible child(ren): _____

☐ my spouse _____ _____

I have chosen to decline health care coverage at this time because:

☐ I and/or my dependents have other group or individual coverage with (*name of insurance company*) _____

through (*insured's name and relationship*) _____

☐ Other reason(s) to waive coverage (please specify): _____

I understand that if, at this time, I decline coverage offered by my employer for myself or my eligible family members, and then choose to apply for coverage later, the plan may exclude coverage, except in the following instances:

1. The individual meets each of the following:

    a. The individual(s) lost coverage as a result of termination of employment or eligibility, the involuntary termination as a result of a qualifying event.
    b. The employer stops contributing towards your or your dependents' other coverage; and
    c. The individual request submits a enrollment application within 30 days after termination or qualifying event.

2. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or

3. If an individual seeks to enroll a dependent(s) during the first sixty (60) days of eligibility, the coverage of the dependent(s) shall become effective:

    a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received after the application is received;
    b. in the case of a dependent's birth, as of the date of such birth; or
    c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

_____ _____
Please print name *Name of group*

_____ _____
Social Security number *Group number*

_____ _____
Employee's signature *Date* *Group administrator's signature* *Date*

Group Employee Benefits EnrollmentForm/ChangeForm

Regular Mail:
Equitable Employee Benefits Group
P.O.Box 1507
Secaucus,NJ 07096
Express Mail:
Equitable Employee Benefits Group
500 Plaza Drive, 6th Floor
Secaucus, NJ 07094

EQUITABLE

For Assistance Call: (866) 274-9887
Email: EBCustomerservice@Equitable.com

Equitable Financial Life Insurance Company
Equitable Financial Life Insurance Company of America

Please Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location:	Effective Date:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	Employer ZIP	State
Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone: ( )	Work Phone: ( )	

☐ New Enrollee	Status Change ☐ Change in Marital Status Date:	☐ Add/Remove Dependents Date:	☐ Other Reason: Date:

Completed by Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete if Electing Medical Coverage)

Type of Coverage			Amount of Coverage
Basic Group Life/AD&D	☑ Yes		$25,000
Dependent Life	☑ Yes		$5,000
Supplemental Employee Life (Any amount above $100k requires EOI) Supplemental AD&D (amount must match Life)	☐ Yes ☐ Yes	☐ No* ☐ No*	Choose between $25,000 and $300,000 in increments of $25,000. $_____
Supplemental Spouse Life - Any amount above $50k requires EOI (Employee must be enrolled to have Spouse/Child Supplemental Life) Supplemental AD&D (amount must match Life)	☐ Yes ☐ Yes	☐ No* ☐ No*	Choose between $5,000 and $100,000 in increments of $5,000. Not to exceed 50% of employee coverage amount. $_____
Supplemental Child Life (Employee must be enrolled to have Spouse/Child Supplemental Life) Supplemental AD&D	☐ Yes	☐ No*	Choose between $2,000 - $10,000 in increments of $2,000. $_____
Core Short-Term Disability	☑ Yes	☐ No	☑ $275
Buy Up Short-Term Disability -See income requirements	☐ Yes	☐ No*	**Mark only one:** ☐ $475 (includes Core benefit) ☐ $675 (includes Core benefit)

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

C. Product Selection - Not eligible for short-term disability (Complete if Waiving Medical Coverage)

Type of Coverage			Amount of Coverage
Basic Group Life/AD&D	☐ Yes	☐ No	$25,000
Dependent Life	☐ Yes	☐ No	$5,000
Must Elect Basic Life in Order to Enroll in Supplemental Life			
Supplemental Employee Life (Any amount above $100k requires EOI) Supplemental AD&D (amount must match Life)	☐ Yes ☐ Yes	☐ No* ☐ No*	Choose between $25,000 and $300,000 in increments of $25,000. $_____
Supplemental Spouse Life - Any amount above $50k requires EOI (Employee must be enrolled to have Spouse/Child Supplemental Life) Supplemental AD&D (amount must match Life)	☐ Yes ☐ Yes	☐ No* ☐ No*	Choose between $5,000 and $100,000 in increments of $5,000. Not to exceed 50% of employee coverage amount. $_____
Supplemental Child Life (Employee must be enrolled to have Spouse/Child Supplemental Life) Supplemental AD&D	☐ Yes ☐ Yes	☐ No* ☐ No*	Choose between $2,000 - $10,000 in increments of $2,000. $_____

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

D. Product Selection (Complete Only if Basic Life/AD&D is Elected)

Type of Coverage	Amount of Coverage	Monthly Premium
Accident	☐ Employee Only ☐ Employee Plus Spouse ☐ Employee Plus Child(ren) ☐ Family	$5.99 $11.13 $12.48 $17.62
Critical Illness Employee ☐ Yes ☐ No ☐ Waive ☐ Smoker ☐ Non-Smoker	Choose between $5,000 and $30,000 in increments of $5,000. $_____	
Critical Illness Spouse ☐ Yes ☐ No ☐ Waive ☐ Smoker ☐ Non-Smoker	Choose between $2,500 and $15,000 in increments of $2,500. Not to exceed 50% of employee coverage amount. $_____	
Critical Illness Child ☐ Yes ☐ No ☐ Waive ☐ Smoker ☐ Non-Smoker	Choose between $2,500 and $5,000 not to exceed 50% of employee coverage amount $_____	

Actual deductions may vary slightly from above illustrations due to rounding. (*If no box is checked for "Smoker" or "Non-Smoker" the Smoker rate will apply.)

E. Dependent and Other Insurance Information (Complete if applying for Spouse or Child coverage)

	Name (Last, First, MI)	SSN (Optional)	Gender	Date of Birth	Full-time Student
Spouse:					☐ Yes ☐ No
Child:					☐ Yes ☐ No
Child:					☐ Yes ☐ No
Child:					☐ Yes ☐ No
Child:					☐ Yes ☐ No

F. Beneficiary Information (Complete for Basic Life/AD&D, Supplemental Life/AD&D, Accident w/AD&D)

Primary Beneficiary's Legal Name (Last, First, MI)	Relationship to Beneficiary	Social Security Number	Distribution % (Total must equal 100%)
Street Address	City	State	Zip
Primary Beneficiary's Legal Name (Last, First, MI)	Relationship to Beneficiary	Social Security Number	Distribution % (Total must equal 100%)
Street Address	City	State	Zip
Contingent Beneficiary's Legal Name (Last, First, MI)	Relationship to Beneficiary	Social Security Number	Distribution % (Total must equal 100%)
Street Address	City	State	Zip
Contingent Beneficiary's Legal Name (Last, First, MI)	Relationship to Beneficiary	Social Security Number	Distribution % (Total must equal 100%)
Street Address	City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than two primary Contingent beneficiaries, please attach a separate sheet of paper.

G. Acknowledgments

By signing this Enrollment form, I understand and agree that:

(1) I authorize my Employer to make required deductions, if any, from my salary to pay the premium for my insurance as elected above once in effect.
(2) All statements and answers I have given are complete and true to the best of my knowledge and belief.
(3) Coverage is not in effect until final approval is given by the Company.
(4) No person, except an officer of the Company, is authorized to vary or modify a contract.
(5) I have read and acknowledge the applicable fraud warning attached.
(6) I, the undersigned agree that statements and answers in all parts of the enrollment form are true and complete to the best of my knowledge and belief.

H. Employee Waiver of Insurance

☐ I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do NOT wish to enroll in the insurance plans offered. Coverage offered by my Employer and not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused. No waivers are allowed for non-contributory coverage. I understand that if I or my dependents decide to apply for this group insurance plan at a later date, Late entrant penalty and/or Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by the Company.

Sign Here	_____ Signature	_____ Date