MUST
MONTANA UNIFIED SCHOOL TRUST

WAIVER FORM

1

First Name:	MI:	Last Name:

Mailing Address:		
City:	**State:**	**ZIP:**
Phone:		
SSN #:	**Gender:**	**Date of Birth:**

2

School District Name:	Group No:

First day at work:	
OR Special Life Event Date:	
Annual salary REQUIRED: $________________________ (Used to calculate member's included Long-Term Disability benefit)	
Work E-mail:	
Title/Classification:	**Hours Worked / Week:**

3

LIFE INSURANCE

1. Are you covered by MUST as a dependent under another policy provided by the same employer? ☐ **Yes** ☐ **No**
2. Does your employer provide Employer Paid Life? ☐ **Yes $___________** ☐ **No**

If you answered Yes to questions 1 and/or 2, please list your Beneficiaries below in section 4.

4

BENEFICIARIES

Primary – Full Name	Mailing Address	Date of Birth	SSN	Relationship	% of Benefit

Contingent- Full Name	Mailing Address	Date of Birth	SSN	Relationship	% of Benefit

5

WAIVER AGREEMENT

I understand that this waiver may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document. I acknowledge that I am also waiving the Basic Life Insurance and Long Term Disability (LTD) benefit provided by the plan, unless I am covered by MUST as a dependent under another policy provided by the same employer. (If covered under another medical coverage complete the Beneficiary section of this application.)

____
SIGNATURE DATE

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: ____________________Q/A INIT__________