



WAIVER FORM

1	First Name:	MI:	Last Name:	2	School District Name:	Group No:
Mailing Address:				First day at work:		
City:				OR Special Life Event Date:		
State:		ZIP:		Annual salary REQUIRED: \$ _____ (Used to calculate member's included Long-Term Disability benefit)		
Phone:				Work E-mail:		
SSN #:		Gender:	Date of Birth:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of person you are covered under: _____	
2. Does your employer provide Employer Paid Life? <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No <i>If you answered Yes to questions 1 and/or 2, please list your Beneficiaries below in section 4.</i>	

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
<p>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.)</p>	
SIGNATURE _____	DATE _____
FOR MUST USE ONLY: Date Entered ____/____/____ NOTES: _____ Q/A INIT _____	