WAIVER FORM

1	First Name:	MI:	Last Name:	2	School District Name:	Group No:
	Mailing Address:				First day at work: OR Special Life Event Date:	
	City:	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: ☐Classified ☐Admin ☐Certified	Hours Worked / Week: _____ ☐ Full-time ☐ Part-time

3 LIFE INSURANCE

1. Are you covered by MUST as a dependent under another policy provided by the same employer? ☐ **Yes** ☐ **No**
   Name of person you are covered under: _____
2. Does your employer provide Employer Paid Life? ☐ **Yes $_____** ☐ **No**
3. Employer paid LTD non-medical participating coverage? ☐ **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, or employer offers LTD non-medical participating coverage. (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_____

Waiver form revised 03/2/2020