WESTERN GROWERS® ASSURANCE TRUST

ENROLLMENT CARD

- ☐ New
- ☐ Name Change
- ☐ Change of Address
- ☐ Add Dependents
- ☐ Plan Change
- ☐ Other ________________
- ☐ Rehire
- ☐ Open Enrollment
- ☐ Change of Beneficiary
- ☐ Delete Dependents

Effective Date ________________

Please fill in all requested information.
Print clearly in blue or black ink and press hard for clear copies.

EMPLOYER USE ONLY

GROUP # ________________

Location: ________________ Employee # ________________

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.	BIRTHDATE
			— —	Mo. / Day / Year

ADDRESS	CITY	STATE	ZIP	PHONE	SEX
					☐ M ☐ F

EMAIL ADDRESS	ALTERNATE PHONE NUMBER

EMPLOYER	JOB TITLE	DATE OF HIRE

NUMBER OF HOURS WORKED / WEEK	Are you actively at work?	Are you covering your dependents?
	☐ YES ☐ NO	☐ YES ☐ NO

CHECK ONE

☐ SINGLE ☐ MARRIED ☐ REGISTERED DOMESTIC PARTNER ☐ UNREGISTERED DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED

(Attach Affidavit of Unregistered Domestic Partnership and Proof of Cohabitation)

DATE OF MARRIAGE Month | Day | Year

PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS TO BE ENROLLED. ATTACH ADDITIONAL SHEETS IF NECESSARY.
IF DEPENDENT CONTACT INFO IS DIFFERENT THAN ABOVE, PLEASE LIST BELOW.

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Husband ☐ Wife ☐ Domestic Partner				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		
DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Son ☐ Daughter				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		
DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Son ☐ Daughter				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		
DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Son ☐ Daughter				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		
DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Son ☐ Daughter				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		
DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DISABLED?
☐ Add ☐ Delete ☐ Son ☐ Daughter				Month / Day / Year		☐ YES ☐ NO
	ADDRESS	EMAIL ADDRESS		PHONE		

Page 1 (Continue to page 2)

ENROLLMENT CARD (CONTINUED)

Do any family members have health coverage with another carrier? ☐ YES ☐ NO Carrier: _____

☐ Myself ☐ Spouse ☐ Children

Are any family members covered by WGAT? ☐ YES ☐ NO Employer: _____

NAME OF INSURED	SOCIAL SECURITY NUMBER	NAME OF OTHER INSURANCE COMPANY	GROUP NO.	
EMPLOYER OF INSURED	**EMPLOYER ADDRESS**	**CITY**	**STATE**	**ZIP**

LIFE INSURANCE BENEFICIARY

LAST NAME	FIRST NAME	RELATIONSHIP

ELECTRONIC DELIVERY OF BENEFIT MATERIALS

Would you prefer to receive updates of benefit materials (or notices of plan updates) electronically rather than through U.S. Mail? ☐ YES ☐ NO

"Benefit plan materials" include explanations of benefits (EOBs), summary plan descriptions, summary annual reports, and any other materials required by the Employee Retirement Income Security Act (ERISA) or the Health Insurance Portability and Accountability Act of 1996 (HIPAA). They are provided in PDF format; if you cannot access PDF documents, you can download the software for free at www.adobe.com. Documents may be viewed in HealthView at ***https://healthview.wga.com***. You may request a paper version of any document without charge by sending an email to ***benefitscompliance@wgat.com***, and may withdraw consent for electronic delivery or update your email address at any time by changing your preferences in **HealthView**.

DECLINATION OF COVERAGE

COVERAGE DECLINATION To be completed if any coverage is declined or refused by any eligible employee and/or their eligible family members.

HEALTH PLAN COVERAGE I decline coverage for: ☐ Myself ☐ Spouse ☐ Children ☐ Spouse & Children

REASON FOR DECLINING HEALTH COVERAGE (check if decline)

☐ Covered by spouse's group coverage ☐ Spouse covered by employer's group medical coverage ☐ Medicare ☐ Healthy Families ☐ Other _____

Although I am eligible to enroll for health coverage and my employer has explained the available coverage options to me, I am knowingly and voluntarily declining group health plan coverage for the reason indicated above.

X _____ _____

Please sign here if declining coverage Date

I have accurately and completely given all applicable information requested on this form. I authorize any insurance company, physician, hospital, clinic or health care provider to give WGAT or its designated agent any and all records pertaining to any medical history, services or treatment provided to anyone listed on this formfor purpose of review, investigation or evaluation.

X _____ _____

EMPLOYEE'S SIGNATURE DATE

Page 2 (Continued from page 1)