WESTERN GROWERS ASSURANCE TRUST®

AG HEALTH BENEFITS ALLIANCE of Northern California

ENROLLMENT FORM

☐ 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.
If enrolling Self and Dependents, please complete sections 1–5.
If enrolling Self and waiving Dependents, please complete Sections 1–6.
If waiving Self and Dependents, please complete section 6.

FOR EMPLOYER USE ONLY

Location: **Employee #:** **Group #:** **Plan:**

SECTION 1

LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NO.	DATE OF BIRTH MM | DD | YYYY

ADDRESS	CITY	STATE	ZIP	SEX ☐ M ☐ F

EMAIL ADDRESS	PHONE

EMPLOYER	JOB TITLE	DATE OF HIRE	DATE OF REHIRE

CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ REGISTERED DOMESTIC PARTNER ☐ UNREGISTERED DOMESTIC PARTNER (IF RECOGNIZED BY EMPLOYER)

LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ OTHER ______

SECTION 2

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

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM | DD | YYYY	SOCIAL SECURITY NO.	DISABLED? ☐ YES ☐ NO
☐ Add ☐ Delete ☐ Husband ☐ Wife ☐ Domestic Partner	ADDRESS		EMAIL ADDRESS		PHONE	

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM | DD | YYYY	SOCIAL SECURITY NO.	DISABLED? ☐ YES ☐ NO
☐ Add ☐ Delete ☐ Son ☐ Daughter	ADDRESS		EMAIL ADDRESS		PHONE	

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM | DD | YYYY	SOCIAL SECURITY NO.	DISABLED? ☐ YES ☐ NO
☐ Add ☐ Delete ☐ Son ☐ Daughter	ADDRESS		EMAIL ADDRESS		PHONE	

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM | DD | YYYY	SOCIAL SECURITY NO.	DISABLED? ☐ YES ☐ NO
☐ Add ☐ Delete ☐ Son ☐ Daughter	ADDRESS		EMAIL ADDRESS		PHONE	

DEPENDENT INFORMATION	LAST NAME	FIRST NAME	MI	DATE OF BIRTH MM | DD | YYYY	SOCIAL SECURITY NO.	DISABLED? ☐ YES ☐ NO
☐ Add ☐ Delete ☐ Son ☐ Daughter	ADDRESS		EMAIL ADDRESS		PHONE	

SECTION 3

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 NO.	NAME OF OTHER INSURANCE COMPANY	GROUP #

EMPLOYER OF INSURED	EMPLOYER ADDRESS	CITY	STATE	ZIP

SECTION 4

ELECTRONIC DELIVERY OF BENEFIT MATERIALS

***Consent to receive marketing and text messages.** I understand, acknowledge, and agree to the following: By entering my email address and phone number, I am consenting to receive information about products, services and updates via email as well as recurring automated text messages like appointment reminders from Western Growers Assurance Trust ("WGAT") through the contact information I have provided. I acknowledge that the frequency of the text messages will vary, and that message and data rates may apply. I may opt-out of emails by clicking the unsubscribe link they contain and may stop text messages by replying with 'STOP'. If I need help, I can reply 'HELP' to any text message or contact customer support at AGCS@aghealthbenefits.org, or by calling (800) 282-2603. I confirm that giving my consent is not tied to making any purchases. I affirm that I have read and understood WGAT's Terms of Use and Privacy Policy (https://www.wgat.com/privacy-policy), and I know how my personal data will be handled. I accept that, as far as the law allows, WGAT cannot be held responsible for delays or errors in the delivery of text or email messages due to circumstances beyond their control. Lastly, I confirm that I am 18 years old or older, or otherwise meet the legal age requirement in my jurisdiction to agree to receive marketing communications.

☐ **Electronic Benefit Materials Opt-In.** By checking this box, I hereby consent to receive electronic delivery of my benefit materials. I understand that WGAT will not send me sensitive or protected health information via email. Instead, WGAT will email me when I have new benefits information available on its secure website, HealthView (https://healthview.wga.com). This will include explanations of benefits, summary plan descriptions, summary annual reports, and other materials required by the Employee Retirement Income Security Act (ERISA) or the Health Insurance Portability and Accountability Act of 1996. To view these documents, I understand that I will be required to create an account on HealthView. All documents on HealthView are in PDF format and if I am unable to access PDFs, I can download the necessary software at www.adobe.com free of charge. I recognize I am entitled to paper copies of ERISA-required documents, and that I can request these at no cost by sending an email to AGCS@aghealthbenefits.org. I also understand that I can withdraw my consent for electronic delivery anytime I choose by either altering my preference in HealthView or emailing AGCS@aghealthbenefits.org.

SECTION 5

LIFE INSURANCE BENEFICIARY

LAST NAME	FIRST NAME	RELATIONSHIP

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 form for purpose of review, investigation or evaluation.

X _____ _____

EMPLOYEE'S SIGNATURE DATE

SECTION 6

DECLINATION OF COVERAGE

EMPLOYER NAME EFFECTIVE DATE

LAST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY NO. DATE OF BIRTH MM | DD | YYYY

COVERAGE DECLINATION HEALTH PLAN COVERAGE

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

I decline coverage for: ☐ Myself ☐ Spouse ☐ Children ☐ Spouse and Children

Reason for declining Health Coverage (check if decline)

☐ Covered by spouse's group coverage ☐ Medi-Cal ☐ VA ☐ Individual Coverage ☐ Medicare ☐ Do Not Want ☐ Medicaid

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.

_____ _____

Please sign here if declining coverage Date