# WAIVER OF SHORT AND/OR LONG-TERM DISABILITY COVERAGE

You must complete and sign this form if you choose to waive disability benefits under your AOM Benefits Trust group benefits plan. Please submit this form to the AOM Benefits Trust along with proof of coverage as noted below.

- You may waive Short and/or Long-Term Disability coverage ONLY if you have comparable coverage through another employer group benefits plan.
- If comparable coverage terminates at a later date, you may apply for disability coverage within 31 days of that coverage terminating and be automatically reinstated. If you do not apply within 31 days, you may be required to provide evidence of insurability (i.e. medical statement) and may be denied coverage.
- Proof of coverage must be provided along with this application in the form of written documentation from your employer/group carrier detailing your current disability coverage.

## 1: PERSONAL INFORMATION

| AOM number: | Last name: | First name: | Middle initial: |
|---|---|---|---|
| | | | |

## 2: WAIVER OF COVERAGE

| I do NOT want (select one OR both): | Other group insurance company name: | Policy number: |
|---|---|---|
| Short-Term Disability coverage | Employer name: | |
| Long-Term Disability coverage | | |

By signing below, I certify that I have been given an opportunity to apply for Short and/or Long-Term Disability coverage. I hereby waive Short and/or Long-Term Disability coverage, as indicated above, under the AOM Benefits Trust group insurance plan because I have comparable coverage through another group plan. I understand that proof of insurability (i.e. medical evidence) may be required if I wish to apply for these benefits at a later date. I understand that I may be denied coverage at that time. If I involuntarily lose my comparable coverage and wish to apply for coverage under the AOM Benefits Trust group benefits plan without providing Evidence of Insurability, I understand that my application for coverage must be received by the AOM Benefits Trust within 31 days after my comparable coverage ends.

| Plan member's signature: | Date signed: YYYY - MM - DD |
|---|---|
| Plan administrator's signature: | Date signed: YYYY - MM - DD |

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