Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation

Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Have you or your spouse used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

1. Life and Accidental Death and Dismemberment (AD&D) Insurance

☐ Life (Employer Paid) ☐ Voluntary Life Your requested amount $ _____
☐ Life with AD&D (Employer Paid) ☐ Voluntary Life with AD&D Your requested amount $ _____
☐ Additional/Optional Life ☐ Additional/Optional Life with AD&D Your requested amount $ _____

2. Dependents Life and AD&D Insurance

☐ Spouse Life Requested amount $_____ ☐ Spouse Life with AD&D Requested amount $_____
Spouse Name _____ Date of Birth _____
☐ Child(ren) Life Requested amount $_____ ☐ Child(ren) Life with AD&D Requested amount $_____

3. Voluntary Accidental Death and Dismemberment (AD&D) Insurance

☐ You only $_____ ☐ Your Spouse $_____ or _____ % ☐ Your Child(ren) $_____ or_____%

4. Supplemental Life Insurance ☐ Your requested amount $_____ ☐ Spouse requested amount $_____

5. Short Term Disability ☐ Employer Paid ☐ Voluntary STD ☐ Buy-up

6. Long Term Disability ☐ Employer Paid ☐ Voluntary LTD ☐ Buy-up

7. Dental (see below) ☐ Employer Paid ☐ Voluntary Dental ☐ Low Dental Plan ☐ High Dental Plan

8. Vision (see below) ☐ Employer Paid Voluntary Balanced Care Vision ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

Dental and Vision *If you are enrolling in Dental and/or Vision, please provide the following information.*

Coverage requested for Dental ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)
Coverage requested for Vision ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)
Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more Dependents? ☐ Yes ☐ No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed.)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

Dental and Vision Insurance Waiver: Contributory Dental and/or Vision Insurance

The Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Insurance coverage may be subject to a Late Enrollment Penalty.

I decline ☐ Dental and/or ☐ Vision Insurance for myself. I decline ☐ Dental and/or ☐ Vision Insurance for one or more Dependents.

Beneficiary *This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 3 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Section 4 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

Member/Employee Signature Required _____ Date (Mo/Day/Yr)_____

Return completed form to your Human Resources Department.