Standard Insurance Company

Enrollment and Change Form

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

MEMBER INFORMATION

Enrollment
☐ Initial Enrollment
☐ Rehire/Reinstatement

Change
☐ Add Dependent ☐ Delete Dependent ☐ Date of add/delete _____
☐ Beneficiary Change ☐ Address Change ☐ Name Change ☐ Other _____

Group Name	Group Number	Division ID	
Your Name (Last, First, Middle)	If name change, what was your former name?	Soc. Sec. No.	
Your Address	City	State	Zip
Date of Birth	☐ Male ☐ Female	Earnings $	Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr
Date of Hire	Hours Worked Per Week	Job Title/Occupation	

COVERAGE SECTION

Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.

1. Life Insurance
☐ Life ☐ Life/AD&D Employer paid amount $ _____ ☐ Additional Life Employee requested amount $ _____
☐ Voluntary Life ☐ Voluntary Life/AD&D Employee requested amount $ _____

2. Dependents Life Insurance
☐ Spouse requested amount $ _____ Spouse Name _____ Date of Birth _____
☐ Children requested amount $ _____

3. Accidental Death and Dismemberment (AD&D) Insurance
☐ Employer paid AD&D ☐ Voluntary AD&D Employee requested amount $ _____

4. Dependents Accidental Death and Dismemberment (AD&D) Insurance
☐ Spouse requested amount $ _____ ☐ Children requested amount $ _____

5. Short Term Disability ☐ Base/Voluntary ☐ Enhanced

6. Long Term Disability ☐ Base/Voluntary ☐ Enhanced

7. Dental *(see below)* ☐ Base/Voluntary ☐ High Plan

DENTAL

Marital Status ☐ Single ☐ Married ☐ Divorced

Coverage requested for ☐ Member, spouse and children ☐ Member and spouse ☐ Member only ☐ Member and children (no spouse)

Are you covered for Dental Insurance under another plan? Member ☐ Yes ☐ No Dependent(s) ☐ Yes ☐ No

Have you had Dental Insurance with us before? ☐ Yes ☐ No If yes, last termination date _____

List dependents you wish to enroll or delete. Add sheet for additional dependents if needed.

Name (Last, First, Middle Initial)	Relationship	Sex M	Sex F	Birth Date Mo.	Day	Yr.

BENEFICIARY

This designation applies to Coverage Section 1 coverage above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Coverage Section 3 coverage above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary 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 apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. 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.

Member Signature Required	Date (Mo/Day/Yr)

Human Resources Department – Retain for your records.