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			

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

Life Insurance ☐ Basic Life with AD&D (Employer Paid) ☐ Additional Life requested amount $_____

Dependents Life Insurance ☐ Spouse Life requested amount $_____ ☐ Child Life requested amount $_____

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

You may choose one of the following options:

☐ You only requested amount $_____ **OR** ☐ You and your Dependents requested amount $_____

Short Term Disability ☐ Voluntary STD

Long Term Disability ☐ Voluntary LTD

Dental/Vision ☐ Voluntary Freedom Plan 1 ☐ Voluntary Freedom Plan 2 ☐ Voluntary Balanced Care Vision

Coverage requested for Dental ☐ You, your Spouse & Children ☐ You & your Spouse ☐ You only ☐ You & your Children (no Spouse)

Coverage requested for Vision ☐ You, your Spouse & Children ☐ You & your Spouse ☐ You only ☐ You & your Children (no Spouse)

Are you covered for dental insurance under another plan? ☐ Yes ☐ No **Other Dental Coverage Will Appear on the Following Page(s)**

List dependents to enroll or delete for Dental/Vision, if applicable (Attach sheet for additional dependents, if needed).

Spouse Full Name	☐ Male ☐ Female	Birth Date
Child 1 Full Name	☐ Male ☐ Female	Birth Date
Child 2 Full Name	☐ Male ☐ Female	Birth Date
Child 3 Full Name	☐ Male ☐ Female	Birth Date

Beneficiary ***This designation applies to Life Insurance available through your Employer, if any. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Accidental Death and Dismemberment (AD&D) Insurance available through your Employer, if any. 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.

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

Return completed form to your Human Resources Department.

Employee Name: _____ SSN: _____

Name	Gender	Birth Date
Child 4	☐ Male ☐ Female	
Child 5	☐ Male ☐ Female	
Child 6	☐ Male ☐ Female	
Child 7	☐ Male ☐ Female	
Child 8	☐ Male ☐ Female	
Child 9	☐ Male ☐ Female	
Child 10	☐ Male ☐ Female	
Child 11	☐ Male ☐ Female	
Child 12	☐ Male ☐ Female	
Child 13	☐ Male ☐ Female	
Child 14	☐ Male ☐ Female	
Child 15	☐ Male ☐ Female	
Child 16	☐ Male ☐ Female	
Child 17	☐ Male ☐ Female	
Child 18	☐ Male ☐ Female	
Child 19	☐ Male ☐ Female	
Child 20	☐ Male ☐ Female	

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.