Reset

Standard Insurance Company

Enrollment and Change

To Be Completed By Administrator

Group Number	Account Number	Date of Employment	Certificate Effective Date
IIAGIT - 170223			

To Be Completed By Employer

Please check one box only	Name of Firm	Firm Phone Number	Account Number
☐ Initial Request ☐ Change Request			

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 and Accidental Death and Dismemberment (AD&D) (Employee amount is employer paid)

Dependent Life Insurance

☐ Spouse Life requested amount $_____ (Increments of $2,500 to a maximum of $10,000)
☐ Child(ren) Life (through age 26) requested amount $_____ (Increments of $2,500 to a maximum of $10,000)
☐ I decline Dependent Life insurance

Voluntary Life Insurance (Employee Paid)

Guaranteed issue: Employees $100,000, Spouses $30,000 if enrolling within 31 days of becoming eligible. Evidence of Insurability is required for amounts over this and for late entrants.

☐ Employee requested amount $_____ (Increments of $10,000 to a $500,000 maximum, not to exceed 5 times Annual Earnings)
☐ Smoker ☐ Non-Smoker
☐ I decline Voluntary Life insurance

Dependent Life Insurance (Additional to Dependent Life insurance above)

☐ Spouse Life requested amount $_____ (Increments of $5,000 to a maximum of $500,000, not to exceed 100% of employee)
☐ Child(ren) Life (through age 26) requested amount $_____ (Increments of $2,000 to a maximum of $10,000)
☐ Add an equivalent amount of Accidental Death and Dismemberment (AD&D)
☐ I decline Dependent Life insurance

If electing Dependent Life on either life products (basic or voluntary), please complete

Spouse Name _____ Date of Birth _____
Child Name _____ Date of Birth _____
Child Name _____ Date of Birth _____
Child Name _____ Date of Birth _____

Short Term Disability

☐ Short Term Disability (Employer Paid)
☐ Voluntary Short Term Disability (Employee Paid)
☐ I decline Voluntary Short Term Disability insurance

Return completed form to your Human Resources Department.

Long Term Disability

☐ Long Term Disability (Employer Paid)
☐ Voluntary Long Term Disability (Employee Paid)
☐ I decline Voluntary Long Term Disability insurance

Beneficiary ***This designation applies to your Life and Accidental Death and Dismemberment Insurance through your Employer, if any. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Total must equal 100%

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) _____

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 Beneficiaries.
- 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.

Print

Return completed form to your Human Resources Department.