Standard Insurance Company **Enrollment and Change Form**

To Be Completed by Human Resources ***Maintain completed form for your records***

Group Number **619080**	***Division***	***Billing Category***	***Date of Eligible Employment***

To Be Completed by Applicant ***Check all boxes and complete all sections that apply. Return completed form to Human Resources.***

Your Name (Last, First, Middle)	Social Security Number	Birth Date	☐ Male ☐ Female
Your Address	City	State	ZIP
Employer Name **City of Salem**	Job Title/Occupation		
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

Change Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Beneficiary Change *Complete the Beneficiary Section below.*

☐ Name Change Former Name: _____

☐ Add Dependent ☐ Delete Dependent Date of add/delete_____ Reason _____

☐ Other_____

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

Electronic Medical History Statement: http://www.standard.com/mybenefits/mhs_ho.html

Additional Employee Paid Life

☐ Employee Additional Life Your requested amount $_____
(Medical History Statement is required for amounts over $100,000)

Additional Dependent Life Insurance

☐ Spouse requested amount $_____ Spouse Name_____ Date of Birth_____
(Medical History Statement is required for amounts over $20,000)

☐ Child(ren) requested amount ☐ $2,000 ☐ $5,000 ☐ $10,000

This designation applies to Employee Voluntary Life through your Employer, if elected. 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

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 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.