Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
111574			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

Your Full Name	Employee Identification	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **COLLABORATIVE EFFORT TO REINFORCE TRANSITION**	Hours Worked Per Week		
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Short Term Disability Insurance
☑ Short Term Disability (Employer Paid)

Long Term Disability Insurance
☑ Long Term Disability (Employer Paid)

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.

Signature of Applicant (Member/Employee)	Date