



The Standard®  
Positively different.

# Voluntary Accidental Death and Dismemberment Insurance

FOR EMPLOYEES OF EMPLOYERS PARTICIPATING IN THE  
WASHINGTON COUNTIES INSURANCE FUND

Answers to your questions about coverage from Standard Insurance Company



STANDARD INSURANCE COMPANY

## About This Booklet

This booklet is designed to answer some common questions about the group Voluntary Accidental Death and Dismemberment (AD&D) insurance coverage offered by Washington Counties Insurance Fund to participating *employers* with eligible employees. It is not intended to provide a detailed description of the coverage.

If coverage becomes effective and you become insured, you will receive a web link to a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the *group policy* issued by Standard Insurance Company. Neither the certificate nor the information presented in this booklet modifies the *group policy* or the insurance coverage in any way. If you have additional questions, please contact your human resources representative.

Please note that defined terms and provisions from the *group policy* are italicized in this booklet.



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## Voluntary AD&D Insurance Features

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you accidentally died or lost a limb? Would your family be financially prepared?

By sponsoring group Voluntary AD&D insurance from Standard Insurance Company, your *employer* offers you an excellent opportunity to help protect your loved ones. With Voluntary AD&D coverage, you or your *beneficiaries*, as applicable, may receive an *AD&D insurance benefit* in the event of death or dismemberment as a result of a covered accident.

The advantages to you and your loved ones include:

**Choice** – You decide how much coverage you need from the range of amounts available.

**Flexibility** – If your needs change, you may request to change the amount of coverage.

**Convenience** – With premiums deducted directly from your paycheck, you don't have to worry about mailing monthly payments.

**Peace of Mind** – You can take comfort and satisfaction in knowing that you have done something positive for your family's future.

### Commonly Asked Questions

The following information provides details to give you a better understanding of group Voluntary AD&D insurance available from The Standard. Written in non-technical language, this is not intended as a complete description of the coverage.

#### Am I eligible for this coverage?

To be a *member* and eligible for the Voluntary AD&D coverage, you must be insured for Basic Life under Group Policy 645273-B and one of the following:

- An active employee of Whatcom County working at least 80 hours each month;
- An active employee of an *employer* participating in the Washington Counties Insurance Fund who is regularly working at least 20 hours each week;
- or
- An active elected official of an *employer*.

Temporary and seasonal employees, leased employees, independent contractors, and full-time members of the armed forces of any country are not eligible.

Provided you become insured, you may also enroll your eligible *dependents*, including your *spouse* and unmarried *children* under age 25. For your *spouse* and *children* to be eligible for coverage, they must not be full-time members of the armed forces of any country.

#### When does my insurance go into effect?

You must apply for Voluntary AD&D coverage and agree to pay premiums. Your Voluntary AD&D coverage becomes effective on the latest of:

- The *group policy* effective date;
- The effective date of your *employer's* participation under the *group policy*, and
- The first day of the calendar month coinciding with or next following the date you become a *member*.

Voluntary AD&D coverage for you, your *spouse* and *children*, if elected, becomes effective on the date you and your *dependents* become eligible. Otherwise, coverage will become effective on the date you apply for coverage, provided you and your *dependents* are eligible on that date.

### How much Voluntary AD&D coverage may I elect?

You may elect Voluntary AD&D coverage in units of \$25,000, from \$25,000 up to a maximum of \$500,000. However, any amount in excess of \$250,000 may not exceed ten times your *annual earnings*.

If you elect coverage for yourself, you may also elect coverage for your *spouse* and *dependent children*. The amount for each *dependent* is as follows:

- *Spouse*, your choice of 50 percent or 100 percent of your coverage
- *Children*, 10 percent of your coverage for each *child*, not to exceed \$30,000

### How much is the AD&D benefit amount?

The amount of the *AD&D insurance benefit* for *loss* of life is equal to the amount of your Voluntary AD&D insurance in effect on the date of the covered accident. The amount of the *AD&D insurance benefit* for other covered *losses* is a percentage of your Voluntary AD&D insurance in effect on the date of the covered accident, as shown below:

Type of Loss	Percentage Payable
One hand or one foot . . . . .	50%
Sight in one eye . . . . .	50%
Audible speech . . . . .	50%
Hearing . . . . .	50%
Thumb and index finger of the same hand <sup>1</sup> . . . . .	25%
Two or more of the <i>losses</i> listed above . . . . .	100%

With respect to a hand or foot, *loss* means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, *loss* means entire and irrecoverable loss of sight. No more than 100 percent of the amount of Voluntary AD&D coverage in effect on the date of the covered accident will be paid for all *losses* incurred by the insured *member* or *dependent* as the result of one accident.

### Are there any limitations?

The *loss* must occur due to an accident and independently of all other causes, within 365 days after the accident. *Loss* of life must be evidenced by a certified copy of the death certificate. All other *losses* must be certified by a *physician* in the appropriate specialty as determined by The Standard.

### Will insurance benefits be reduced as I grow older?

Under this plan, your Voluntary AD&D coverage will be reduced to 65 percent of the original amount at age 70, 45 percent at age 75, 30 percent at age 80, 20 percent at age 85, 15% at age 90, and 10% at age 95.

<sup>1</sup> This benefit is not payable if an AD&D insurance benefit is payable for the *loss* of the entire hand.

### Are there any exclusions?

*AD&D insurance benefits* are not payable for death or dismemberment caused or contributed to by:

- *War* or act of *war*
- Suicide or other intentionally self-inflicted *injury*, while sane or insane
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a *physician*
- *Sickness* or *pregnancy* existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above
- Boarding, leaving or being in or on any kind of aircraft if you are a pilot or crew member of the aircraft, or a passenger in an aircraft operated by or for your *employer*

### When does coverage end?

Voluntary AD&D insurance ends automatically on the earliest of the following:

- The date you cease to be a *member*; however, insurance may continue for limited periods under certain circumstances described in the *group policy*
- The date the *group policy* terminates
- The date the last period ends for which a premium was paid for your Voluntary AD&D insurance
- For your *spouse*, the date of your divorce or termination of your *domestic partner* relationship
- For any *dependent*, the date the *dependent* ceases to be an eligible dependent
- For a *disabled child*, 90 days after The Standard requests proof of *disability*, if proof is not received
- The date your *employer* ceases to participate under the *group policy*

### Are there any other benefits with the Voluntary AD&D insurance coverage?

The AD&D coverage includes the following benefits when an *AD&D insurance benefit* is payable.

#### Seat Belt Benefit

The *Seat Belt Benefit* provides an additional *AD&D insurance benefit* if an insured employee or *dependent* dies as a result of an automobile accident for which an AD&D benefit is payable while wearing a *seat belt*. The benefit is equal to the amount of the *AD&D insurance benefit* payable for *loss of the life*, up to a maximum of \$10,000.

### Higher Education Benefit

The plans for a child's higher education should not end with the death of a parent. The *Higher Education Benefit* helps to keep those dreams alive by paying an additional amount to your eligible *children* in the event of your accidental death. To be eligible, your surviving *child* must register and attend an institution of higher education on a full-time basis within 12 months after your death. The benefit is paid annually for a maximum of four consecutive years beginning on the date of death. The amount payable is 5 percent of your Voluntary AD&D coverage in effect on the date of the accident, up to a maximum of \$5,000 per year for four years, as long as the *child* remains eligible.

This benefit will be paid in addition to any other *AD&D insurance benefit* payable for the same accident. If you have no surviving *child* eligible to receive this benefit, it will not be paid.

### Career Adjustment Benefit

Your surviving *spouse* may need to make a career adjustment as a result of your accidental death. The *Career Adjustment Benefit* may help make this transition easier. It pays an additional benefit to your surviving *spouse* if your *spouse* was insured for Voluntary AD&D coverage at the time of the accident. The amount payable is 5 percent of your Voluntary AD&D coverage in effect on the date of the accident, up to a maximum of \$5,000.

This benefit will be paid in addition to any other *AD&D insurance benefit* payable for the same accident. If you have no surviving *spouse*, this benefit will not be paid.

### Paralysis Benefit

A benefit for paralysis may be paid if you or your *dependent* suffers paralysis caused by an accident within one year of the date of that accident. The *benefit* is equal to a percentage of the Voluntary AD&D coverage in effect on the date of the accident, as shown below:

Type of Loss	Percentage Payable
<i>Quadriplegia</i> .....	100%
<i>Hemiplegia</i> .....	50%
<i>Paraplegia</i> .....	50%

*Quadriplegia* means the permanent, complete and irreversible total paralysis of both upper and lower limbs. *Hemiplegia* means the permanent, complete and irreversible total paralysis of the upper and lower limb on the same side of the body. *Paraplegia* means the permanent, complete and irreversible total paralysis of both lower limbs.

## Common Disaster Benefit

In the event both you and your *spouse* insured as a *dependent* die as the result of the same covered accident, the *Common Disaster Benefit* will pay 200 percent of your Voluntary AD&D insurance in effect on the date of the accident.

Any *Common Disaster Benefit* will be paid in equal shares to each of your surviving children. If you have no surviving children, the increased benefit will not be paid.

## How much will the Voluntary Accidental Death and Dismemberment coverage cost?

Use the following rates to determine the monthly premium for your Voluntary AD&D coverage.

Coverage	Cost per \$1,000 of Coverage
Employee.....	\$.025
Spouse.....	\$.025
Child.....	\$.030

To calculate your employee or *spouse* Voluntary AD&D premium:

$$\begin{array}{l} \$ \underline{\hspace{2cm}} \div \$1,000 = \underline{\hspace{2cm}} \times \$0.025 = \$ \underline{\hspace{2cm}} \\ \text{Amount Elected} \hspace{15em} \text{Your monthly cost} \end{array}$$

To calculate the premium for your *child* Voluntary AD&D coverage:

$$\begin{array}{l} \$ \underline{\hspace{2cm}} \div \$1,000 = \underline{\hspace{2cm}} \times \$0.030 = \$ \underline{\hspace{2cm}} \\ \text{Amount Elected} \hspace{15em} \text{Your monthly cost} \end{array}$$

## How do I apply for Voluntary AD&D insurance coverage?

To apply for the group Voluntary AD&D insurance, complete the Enrollment Form in your enrollment packet, place it in a confidential envelope and submit it to your human resources department. You can apply at any time.

## What if I have additional questions?

If you have any additional questions, please contact your human resources representative.

**DIRECTIONS FOR APPLYING FOR COVERAGE**

*Read the Information Practices Notice(s) on page 3. Complete all items, date and sign in the space at the bottom of page 2. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Please keep a copy for your records.*

**MEMBER/EMPLOYEE INFORMATION**

Name of Group and Group Number <b>Washington Counties Insurance Fund/Pool – 645273</b>		Employer Name and Location		Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name			Birthdate (Mo/Day/Year)		Date Hired (Mo/Day/Year)
Occupation		Salary	Social Security Number		Member/Employee Identification No.

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured)					
Street Address			City	State	Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (Mo/Day/Year)	Birthplace		Social Security Number	Work Phone ( ) Home Phone ( )

**APPLICATION INFORMATION**

Type of Application ( <i>check one</i> ) <input type="checkbox"/> Initial <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Late Application					
<b>Check the type and provide details on the amount of coverage you are requesting.</b>					
<input type="checkbox"/> Short Term Disability					
<input type="checkbox"/> Long Term Disability					
	Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested
<input type="checkbox"/> Life					
	Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested
<input type="checkbox"/> Dependents Life					
	Current Amount In Force, if any	+	Additional Amount Requested	=	Total Amount Requested

**MEDICAL HISTORY STATEMENT QUESTIONS**

- Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.**
- Are you now unable to work full-time because of any physical or mental condition, or injury?  Yes  No
  - Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
    - Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder?  Yes  No
    - Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder?  Yes  No
    - Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth?  Yes  No
    - Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders?  Yes  No
    - Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease?  Yes  No
    - Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)?  Yes  No
    - Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions?  Yes  No
    - Diabetes, thyroid, gland, spleen, or nephritis?  Yes  No
    - Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment?  Yes  No
    - Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder?  Yes  No
  - In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits?  Yes  No
  - Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
  - Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury?  Yes  No
  - Are you currently pregnant?  Yes  No

Height	Weight	Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address)

Applicant Name	Social Security Number
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**Describe any "yes" answers below. (Please provide the entire question number.)**

Question Number	Description of Injuries, Disorders and Operations	Month/Year	Duration	Final Result	Physicians Consulted, City & State

**ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION** *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

<b>Signature of Applicant</b> (or Member/Employee for Dependent Child)	<b>Date</b>
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*Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.*

Applicant Name	Social Security Number
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**INFORMATION PRACTICES NOTICE**

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.  
 Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.  
 Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.

**FRAUD NOTICE**

- FOR RESIDENTS OF ARKANSAS, LOUISIANA, OHIO, WASHINGTON: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- FOR RESIDENTS OF DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.**

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>Washington Counties Insurance Fund (WCIF)</b>		Group Number(s) <b>645273</b>																															
	Your Address		City		State	ZIP																														
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female																																
	Your Employer			Job Title/Occupation																																
<b>LIFE</b>	<p><i>Check with your Human Resources Department about coverage options available to you.</i>  <b>Voluntary Accidental Death and Dismemberment (AD&amp;D) Insurance</b>  <i>Employee must be insured under the plan to be eligible to elect coverage for the Spouse and or eligible Child(ren).</i></p> <p><input type="checkbox"/> Employee Only Your requested amount \$ _____</p> <p>Dependents Insurance</p> <p><input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____</p> <p><input type="checkbox"/> Children requested amount \$ _____</p>																																			
	<p><i>This designation applies to Accidental Death and Dismemberment (AD&amp;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.</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Primary - Full Name</th> <th style="width:30%;">Address</th> <th style="width:15%;">Soc. Sec. No.</th> <th style="width:10%;">Relationship</th> <th style="width:15%;">% of Benefit</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Contingent - Full Name</th> <th style="width:30%;">Address</th> <th style="width:15%;">Soc. Sec. No.</th> <th style="width:10%;">Relationship</th> <th style="width:15%;">% of Benefit</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>						Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit											Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit										
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<p><b>CHANG</b> <i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i></p> <p><input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change</p> <p>Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____</p>																																				
<b>SIGNATURE</b>	<p>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.</p>																																			
	Member/Employee Signature Required				Date (Mo/Day/Yr)																															
<p><b>Human Resources Department - Complete this section. Retain form for your records.</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">Dvsn ID <b>0001</b></td> <td style="width:10%;">Billing Cat. <b>0100</b></td> <td style="width:20%;">Date of Hire/Rehire</td> <td style="width:15%;">Hrs. Worked Per Wk.</td> <td style="width:20%;">Earnings \$ _____</td> <td style="width:10%;">Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr</td> </tr> </table>							Dvsn ID <b>0001</b>	Billing Cat. <b>0100</b>	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr																								
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## 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.

## About Standard Insurance Company

Your employer has chosen Standard Insurance Company to provide group Voluntary AD&D coverage to eligible employees. The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Just as others count on you, you can count on The Standard for Voluntary AD&D insurance in a time of need. Talk with your employer's human resources representative for more information about group Voluntary AD&D insurance from The Standard.



The Standard®  
Positively different.

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[www.standard.com](http://www.standard.com)

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