Reset

WA Health Care Authority
Public Employees Benefits Board (PEBB) Program
Long Term Disability (LTD) Insurance
Enrollment and Change Form

Standard Insurance Company

To Be Completed By Employee ☐ Apply for Coverage ☐ Name Change ☐ Making a Benefit Change

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	Employee I.D. Number	
Your Address		City	State	Zip Code
Former Name (Last, First, Middle) *Complete only if you are reporting a name change*		Phone Number	☐ Male ☐ Female	
Job Title/Occupation				
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Long Term Disability (LTD) Insurance Coverage

I wish to:

☒ Enroll in basic LTD (Employer Paid)

☐ Enroll in supplemental LTD (Employee Paid); choose a waiting period.
☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Increase the waiting period for my supplemental LTD coverage; choose a waiting period.
☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Decrease the waiting period for my supplemental LTD coverage; choose a waiting period.
☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Cancel my supplemental LTD coverage.

If you request supplemental LTD coverage after 31 days of becoming newly eligible for PEBB coverage or decrease the waiting period for your supplemental LTD coverage, you must also complete the LTD Evidence of Insurability form. **Note**: Send the Evidence of Insurability form to Standard Insurance Company (The Standard) at 900 SW 5th, Portland, OR 97204-1282 or call 1-800-368-2860. Enrollment and Change Forms are maintained by the PEBB employer and should not be sent to The Standard.

To Be Completed By Personnel, Payroll, or Benefits Office Staff

Employer Name **WA Health Care Authority** **Public Employees Benefits Board (PEBB) Program**		Group Number **377661**	Effective Date of Coverage *(if no approval required)*
Agency Name		Agency Code	
Current Agency Hire Date	Initial Eligibility Date for PEBB Benefits	Employee's Current Coverage ☐ basic LTD ☐ supplemental LTD – waiting period _____days	

Signature I wish to make the choices selected 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.

If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard has the right to refuse my request for insurance. I understand that coverage(s) not elected will not become effective. I must select both a level and timing (waiting period) of coverage for it to become effective.

This form replaces all previous forms and submissions I have made for the PEBB Program's long term disability coverage.

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

Print

Return completed form to your personnel, payroll or benefits office.