

Mark all boxes and complete all sections that apply. Return completed form to your Employee Benefits Office.

APPLICANT	Your Name (Last, First, Middle)		Group Name CITY OF MESA		Group Number(s) 642929																														
	Your Address		City		State	ZIP																													
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation																														
LIFE	<i>Check with your Employee Benefits Office about coverage options available to you and Evidence Of Insurability requirements.</i> Life Insurance <input checked="" type="checkbox"/> Life with AD&D Employer Paid Additional Life <input type="checkbox"/> Additional Life Your requested amount \$ _____ Total Employee Additional Life \$ _____ Dependents Life Insurance <input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Children requested amount \$ _____																																		
	DISABILITY	<i>Check with your Employee Benefits Office about coverage options available to you and Evidence Of Insurability requirements.</i> Short Term Disability <input type="checkbox"/> Voluntary STD Employee status, choose one <input type="checkbox"/> New Hire <input type="checkbox"/> New Enrollee/Late Applicant <input type="checkbox"/> Presently Enrolled Employee Select Coverage Type you are requesting <input type="checkbox"/> 14-day waiting period <input type="checkbox"/> 29-day waiting period <input type="checkbox"/> 44-day waiting period <i>Review your STD Coverage Highlights for details regarding the Benefit Waiting Periods listed above.</i>																																	
		<i>This designation applies to Life/Life with AD&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> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Primary - Full Name</th> <th style="width:33%;">Address</th> <th style="width:10%;">Soc. Sec. No.</th> <th style="width:10%;">Relationship</th> <th style="width:10%;">% 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> <tr> <th>Contingent - Full Name</th> <th>Address</th> <th>Soc. Sec. No.</th> <th>Relationship</th> <th>% of Benefit</th> </tr> <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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CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Change in Family Status Qualifying Event: _____ <input type="checkbox"/> Cancel Dependent Coverage <input type="checkbox"/> Cancel Employee Additional Life Insurance <input type="checkbox"/> Cancel STD Insurance																																		
	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. If canceling 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 will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.																																	
		Member/Employee Signature Required				Date (Mo/Day/Yr)																													
Employee Benefits Office – Complete this section. Retain form for your records.																																			
Division ID Full-Time	Billing Category	Date of Hire or Rehire	Hours Worked Per Week	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> 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.