

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

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>CITY OF MESA</b>		Group Number(s) <b>642929</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
<b>DISABILITY</b>	<p><i>Check with your Employee Benefits Office about coverage options available to you and Evidence Of Insurability requirements.</i></p> <p><b>Short Term Disability</b>  <input type="checkbox"/> Voluntary STD</p> <p><b>Employee status, choose one</b>   <input type="checkbox"/> New Hire   <input type="checkbox"/> New Enrollee/Late Applicant   <input type="checkbox"/> Presently Enrolled Employee</p> <p><b>Select Coverage Type you are requesting</b>  <input type="checkbox"/> 14-day waiting period   <input type="checkbox"/> 29-day waiting period   <input type="checkbox"/> 44-day waiting period</p> <p><i>Review your STD Coverage Highlights for details regarding the Benefit Waiting Periods listed above.</i></p>					
	<p><b>CHANGE</b></p> <p><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"/> Name Change      Date of add/delete _____      Former name _____</p> <p><input type="checkbox"/> Change in Family Status      Qualifying Event _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Cancel STD Insurance</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> <p>I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.</p>					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
<b>Employee Benefits Office – Complete this section. Retain form for your records.</b>						
Division ID <b>Full-Time</b>	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		