

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, AZ		Group Number(s) 642929-A	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
LIFE	Check with your Employee Benefits Office about coverage options available to you and Evidence Of Insurability requirements. Life Insurance <input checked="" type="checkbox"/> Life with AD&D Employer Paid					
	Additional/Optional Life <input type="checkbox"/> Additional/Optional Life Your requested amount \$ _____ Total Employee Optional Life \$ _____					
	Dependents Life Insurance <input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Children requested amount \$ _____					
BENEFICIARY	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.					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
	<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"/> Cancel Dependent Coverage		<input type="checkbox"/> Cancel Employee Optional Life Insurance		<input type="checkbox"/> Cancel STD Insurance		
SHORT TERM DISABILITY	Are you: <input type="checkbox"/> New Hire (no delayed benefit waiting period) <input type="checkbox"/> New Enrollee/Late Applicant <input type="checkbox"/> Presently Enrolled – changing waiting period <input type="checkbox"/> Change in Family Status Qualifying Event: _____					
	Select Coverage Type: <input type="checkbox"/> 30-day waiting period <input type="checkbox"/> 15-day waiting period					
	PLEASE NOTE: If you are not presently enrolled in STD, or wish to switch from the 30-day waiting period to the 15-day waiting period, you will have a delayed 60-day waiting period during the first 12 months of coverage. This will apply to sickness (including pregnancy) only. This does not apply to accidents.					
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
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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.