

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

APPLICANT	Your Name (Last, First, Middle)		Group Name State of Wyoming		Group Number(s) 645750	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
DISABILITY	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Short Term Disability <input type="checkbox"/> Voluntary STD Long Term Disability <input type="checkbox"/> Voluntary LTD					
	<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"/> Name Change Former name _____ <input type="checkbox"/> Other _____					
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.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
Human Resources Department - Complete this section. Retain form for your records.						
Dvsn ID	Billing Cat.	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	