Reset

Standard Insurance Company
CSU Benefits Team
900 SW Fifth Avenue
Portland, Oregon 97204

Voluntary Insurance Enrollment Form

Check with your plan administrator, or call The Standard at 1-800-378-5745, if you have any questions concerning the coverage options that apply to your group. Complete this form only if requesting coverage that is at or below the Guarantee Issue Amount. If you are requesting coverage in excess of the Guarantee Issue Amount, requesting an increase in existing coverage, or if this is a late application, you must complete an enrollment/ medical history form.

EMPLOYER USE ONLY

Employer Name **The California State University** Group I.D. - VT **101770**

MEMBER INFORMATION

Your Name *(Last, First, Middle)* Campus _____

Social Security # Date of Birth ☐ Male ☐ Female

Your Address

City State Zip Telephone: Home ( ) Work ( )

Hours worked per week

Date of Hire Job Title

Spouse Name* *(Last, First, Middle)*

Social Security # Date of Birth ☐ Male ☐ Female

* Spouse includes domestic partner

REASON FOR APPLICATION

☐ Member: ☐ Initial Enrollment
☐ Reinstatement / Rehire Date .....
☐ Adding Dependents: Date of marriage .....
Date of domestic partnership filing .....
Date of birth/adoption .....

VOLUNTARY COVERAGE

Coverage(s) applying for: ☐ Life

☐ Member Amount Requested ..... $

☐ Spouse Amount Requested ..... $

☐ Child ☐ $5,000 ☐ $10,000 ☐ $20,000

BENEFICIARY

BENEFICIARY – **Please see reverse side of form for Beneficiary Rules and Instructions.**

PRIMARY – Full Name	Address	Social Security #	Date of Birth	Relationship

CONTINGENT – Full Name	Address	Social Security #	Date of Birth	Relationship

SIGNATURE

I hereby apply for insurance under the provisions of the Group Policy(ies) for which I am eligible. I authorize deductions from my wages to cover the cost of this insurance. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief.

Member Signature Required Date *(Mo/Day/Yr)*

Send to Standard Insurance Company.

Beneficiary Rules

If there is not enough room on this form to name all your Beneficiaries, please make your entire designation on a separate sheet of paper, following the format shown on the front of this form. Be sure to sign and date the separate sheet, and attach it to this form.

Your designation: (1) revokes all prior designations; and (2) applies to all of your Voluntary Life Insurance and Accidental Death and Dismemberment Insurance, if any. Dependents Insurance, if any, is payable to you, if living, or as provided under the terms of your Employer's coverage under the Group Policy. Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary*(ies)*. Unless specified otherwise: (1) benefits will be divided equally between Beneficiaries in the same class (primary or contingent); and (2) if a Beneficiary predeceases you, the Beneficiary's share will be divided equally among surviving Beneficiaries of the same class. If no Beneficiary (primary or contingent) survives you, payment will be made under the terms of your Employer's coverage under the Group Policy.

Beneficiary Instructions

- Please provide the full name and address, Social Security Number, date of birth and relationship of your Beneficiary*(ies)*.

- 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 questions, consult your legal advisor.

The California State University

Payroll Deduction Authorization

075–117				
Ded/Org Code	Last Name	First Name	M.I.	Social Security No.

Employee-Paid Portable Term Life Insurance – Standard Insurance Company

Organization Name

I hereby authorize the State Controller to deduct from my salaries and wages the amount specified now or in the future for membership dues and any benefit program for which I have applied, which is sponsored by the above named organization.

This authorization will remain in effect until cancelled by me or by the above named organization.

I certify I am a member of the above named organization and understand that termination of membership will cancel all deductions made under this authorization.

Signed _____ Date _____

Return this form with your application to Standard Insurance Company in the envelope provided.

You should complete the Medical History Statement only if you are enrolling more than 60 days after becoming eligible, are applying for coverage for yourself in excess of the Guarantee Issue Amount of $150,000, are applying for Dependents Life Insurance for your Spouse/Domestic Partner in excess of the Guarantee Issue Amount of $50,000, or for any increase in coverage.

If you do not need to complete the Medical History Statement, print using the print button below. If you complete the Medical History Statement, print using the print button on the last page.

STANDARD INSURANCE COMPANY **The California State University**

Print Previous Pages Only

INSTRUCTIONS FOR COMPLETING THE STANDARD VOLUNTARY INSURANCE ENROLLMENT FORM

PLEASE NOTE:

This form must be completed:

- If requested coverage exceeds the Guarantee Issue Amount.
- If requesting an increase in existing coverage.
- If this is a late application.
- Provide Spouse information in **Part A** only if applying for Dependent Spouse Insurance.
- If you and/or your Dependent(s) are required to complete **Part B**, then each person to be insured must complete a separate Enrollment Form.

Please refer to the Standard Voluntary Insurance folder ("Protecting What's Priceless") or check with your plan administrator if you have questions concerning the Guarantee Issue Amount or late application requirements.

WHEN COMPLETING THE ENROLLMENT FORM

- Please answer all the questions completely and accurately. Unanswered questions or unclear responses will delay a decision on this request for coverage.
- Indicate the type and amount of coverage requested, and the Member's salary.
- Include both your WORK and HOME phone numbers. If we need to have more information, this will make it easier for us to reach you.

When completing Part B:

- Use complete name and mailing address of the physician or facility that has your medical records. If you have consulted any other physicians, please include their names and mailing addresses.
- Provide full details to any "yes" answer in the space provided. Use a separate sheet of paper if necessary. Include dates, treatment and final results.
- Sign and date the authorization and retain a copy of the Enrollment Form for your records. Place the original in a sealed envelope and return to Standard Insurance Company.

In order to evaluate this application, we are relying on the information you have provided. We may also need to request additional information from you or your physician, and a brief examination, blood test and urinalysis may be required. Should these tests be necessary, they will be requested by Standard. You will receive notification if additional information is needed.

If you have any questions concerning **Part B**, please feel free to contact us at 1–800–843–7979.

STANDARD INSURANCE COMPANY • **CSU Benefits Team**
900 SW Fifth Avenue Portland OR 97204

PART A

Standard Voluntary Insurance Enrollment Form

Employer	Coverage Selection:
The California State University	LIFE: Member: ☐ Initial Amount $_____. ☐ Coverage Increase. Amount of Increase $ _____. Spouse: ☐ Initial Amount $ _____. ☐ Coverage Increase. Amount of Increase $ _____. Child: (Check one box) ☐ $5,000 ☐ $10,000 ☐ $20,000
Group I.D. VT– **101770** / Division I.D. (Internal Use)	

Member Name	S.S. No.	Birthdate	Birthplace	☐ Male ☐ Female
Occupation	Monthly Salary	Hire Date	Work Hours Per Week	
Address (Street, City, State, Zip)		Phone: Home ( )	Work ( )	
Spouse Name	S.S. No.	Birthdate	Birthplace	☐ Male ☐ Female
Address (if different)		Phone: Home ( )	Work ( )	

Name of Beneficiary (Member is beneficiary for Dependent Spouse and Child Insurance): _____

Mailing Address of Beneficiary _____ Relationship to Member _____

NOTE: This designation supersedes any prior designation. It is effective as to existing coverage, even if made in connection with an application requiring the completion of **Part B** that is declined.

I hereby apply for insurance under the provisions of the Group Policy(ies) for which I am eligible. I authorize deductions from my wages to cover the cost of this insurance. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief.

Member Signature _____ Date _____

Check Person to be Insured (One Per Form for Part B): ☐ Member ☐ Spouse ☐ Child

Person to Be Insured	S.S. No.	Birthdate	Birthplace	☐ Male ☐ Female
Address (Street, City, State, Zip)		Phone: Home ( )	Work ( )	

PART B

This section to be completed only if requesting amounts in excess of the Guarantee Issue Amount, requesting an increase in existing coverage, or if this is a late application.

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH YOUR COMPLETE MEDICAL RECORDS
		NAME FULL MAILING ADDRESS

Check yes or no for each of these questions, and give details for any "yes" answers after #9. (Attach a separate sheet if more room is required.)

1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? ☐ Yes ☐ No
2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? ☐ Yes ☐ No
3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   - A. High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? ☐ Yes ☐ No
   - B. Mental condition, depression, epilepsy, or nervous system disorder? ☐ Yes ☐ No
   - C. Cancer, diabetes, or nephritis? ☐ Yes ☐ No
   - D. Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? ☐ Yes ☐ No
   - E. Lung, kidney, stomach, genital, urinary, or intestinal ailment? ☐ Yes ☐ No
   - F. Blindness or deafness? ☐ Yes ☐ No
   - G. Acquired Immune Deficiency Syndrome (AIDS), AIDS–Related Complex (ARC), or an immune system disorder? ☐ Yes ☐ No
5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? ☐ Yes ☐ No
6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths? ☐ Yes ☐ No
7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? ☐ Yes ☐ No
9. Are you now pregnant? ☐ Yes ☐ No

Describe below any "yes" answers which were given for questions on page 1. (Please provide the entire question number.)

Question #	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

Acknowledgment and Authorization for Release of Information. (Please read carefully.)
I represent that the statements contained herein, including those made in page 2 and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, Standard's liability is limited to the return of any premium which may have been paid.

I acknowledge that I have read and received the Information Practices Notice, and I have kept a copy of this Enrollment form.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or any employer: I authorize you to release to Standard or its reinsurers all medical information you have about me including medical history, diagnosis, prognosis and treatment of any physical, mental or emotional condition. I understand that Standard will use the information obtained by this authorization to determine my eligibility for group insurance coverage. I further authorize Standard to release this information to its reinsurers, MIB, and to other insurance companies to which I have applied for insurance coverage or benefits.

I understand a copy of this authorization will be provided upon request. This authorization will remain valid one year from the date below. A photocopy of this authorization shall be as valid as the original.

SIGNATURE OF APPLICANT (OR MEMBER FOR DEPENDENT CHILD) **DATED**

INFORMATION PRACTICES NOTICE

To help us determine your eligibility for group insurance, we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed above when we seek this information.

MIB (MEDICAL INFORMATION BUREAU) – Information we collect about you is confidential. However, Standard Insurance Company or its reinsurers may make a brief report to the MIB. MIB is a nonprofit corporation. It exchanges information among its member life insurance companies. If you later apply to another MIB member company for life or health insurance coverage, or if you submit a claim for benefits to such member company, MIB will supply the member company with any information it has about you in its files. This will be done only upon the member company's request. Standard or its reinsurers may also release information about you to Standard's reinsurers or to other insurance companies to whom you have applied for life or health insurance or made claim for benefits.

MIB will disclose any information it has about you at your request. If you believe that the information MIB has about you is incorrect, you may contact MIB and request a correction. Your request for correction will be handled by MIB in accordance with the procedures outlined in the federal Fair Credit Reporting Act. The address of the MIB information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112. MIB's telephone number is (617) 426-3660.

DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.

YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at: Medical Underwriting Department, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204-1282, 1-800-843-7979

PLEASE RETAIN A COPY FOR YOUR RECORDS.