Standard Insurance Company
CTA Benefits and Services
PO Box 4744 Portland OR 97208
Tel 800.522.0406 Fax 888.414.0393

Reset

Participant Change for CTA-Endorsed Plans

For additional information and forms go to: www.CTAMemberBenefits.org/TheStandard

Use this form only when you wish to make a change after insurance becomes effective. If you have had a qualifying family status change in the last 60 days and would like to apply for additional coverage, please also complete and submit an enrollment form. Changes will not be retroactive. Mark all boxes that are applicable and complete all sections that apply. Please return completed form to The Standard at the address above.

Employee Information ** Required fields.*

SIC USE ONLY PARTICIPANT ID		POLICY NO.			
FIRST NAME *		MIDDLE INITIAL	LAST NAME *		
MAILING ADDRESS *		CITY *		STATE *	ZIP *
PRIMARY PHONE	SECONDARY PHONE	HOME EMAIL ADDRESS	SCHOOL DISTRICT * *Please do not abbreviate.*		

Changes

☐ Name Change - Former Name _____

☐ Address Change

☐ Salary Change New Gross Annual Salary $ _____

☐ Reinstatement Date Returning to Work _____

Select coverage(s) to reinstate: ☐ **ALL COVERAGES** ☐ Disability ☐ Life ☐ Dependents Life

You must inform The Standard within 120 days of returning to work to reinstate your coverage without proof of good health.

☐ Other _____

Signature Required

I wish to make the choices indicated on this form. If electing coverage, I authorize my employer to deduct premiums from my wages to cover my cost of insurance sponsored by California Teachers Association. I understand that my employer may provide updated payroll information to The Standard either periodically or at The Standard's request to ensure proper premium deductions are being made for my coverage. I understand that a copy of this form will be provided to my employer to facilitate payroll deduction for the coverages that I have elected. I understand that my premium deduction amount will change if my coverage or costs change. This authorization will remain in effect until cancelled by me or by The Standard. I certify that I am a member of California Teachers Association and understand that termination of CTA membership will cancel my coverage and deductions.

FRAUD NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Participant Signature _____ Date _____

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