

To Be Completed By Applicant

Eligible Excluded Employee Instructions: Please complete all sections. Fill out online or use a ball-point pen and print clearly. Please return the completed form to your departmental personnel office and keep a copy for your records.

Type of Enrollment or Change

- Apply for New Coverage Change Coverage Option Cancel Coverage Reinstatement
 Add Dependent Delete Dependent Date of Add/Delete _____
 Beneficiary Change **Complete Beneficiary Section.** Name Change Former Name _____

Your Full Name (Last, First, Middle)		Your Social Security Number		Birth Date	
Address		City		State	ZIP
Email		Phone Number		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Job Title/Occupation		Monthly Base Salary	Hours Worked Per Week	Are You Actively At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Basic Allowance for Housing (BAH) Amount <i>(if applicable)</i>			Basic Allowance for Subsistence (BAS) Amount <i>(if applicable)</i>		

Coverage

Check with your departmental personnel office about coverage options and minimum and maximums available to you. Premium rates and amounts are included within the employee benefits guide at standard.com/eforms/20564_643146.pdf.

Long Term Disability Insurance

- 55% option (075-119)
 65% option (075-111)

You can calculate your monthly premiums at standard.com/mybenefits/calcalc/premium-ltd.html.

Accident Insurance

- You only
 You and your spouse/domestic partner

Critical Illness Insurance

- A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No", you are not eligible for Critical Illness.) Yes No
B. Are you age 65 or older? (If you answer "Yes", you are not eligible for Critical Illness.) Yes No
 Employee* requested amount \$10,000
 Spouse/domestic partner requested amount \$10,000

*Eligible child(ren) are automatically covered at 50% of your coverage amount.

Return completed form to your departmental personnel office.

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.

Department of Human Resources Privacy Policy: calhr.ca.gov/privacy-policy

The Standard Privacy Notice: standard.com/get-to-know-standard/legal-privacy/standards-privacy-notice

To Be Completed By Personnel Office

Agency Name <input type="checkbox"/> CAL Fairs <input type="checkbox"/> CAL Expo <input type="checkbox"/> Military <input type="checkbox"/> Other	Agency Code	Organization Code 075
CBID	Deduction Code(s)	Date Received (Mo/Day/Yr)
Remarks/Eligibility Date for "Newly Eligible Employees" (Beginning and End Date)		
Authorized Agency/Personnel Office Representative Signature I certify that authorization for payroll deductions signed by this employee is on file in this office.		
Signature of Representative	Phone Number	Date (Mo/Day/Yr)

Agency/Personnel Office Form Distribution: Employee Employee's Personnel File The Standard (socltforms@standard.com)

Return completed form to your departmental personnel office.