

To Be Completed By Your Plan Administrator

Group Number 643865	Division	Billing Category	Date of Membership
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address	Email Address	City	State ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name CASE	Job Title/Occupation	Are You Actively At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Coverage Check with your Plan Administrator about coverage options available to you and Evidence Of Insurability requirements. If you choose not to elect any coverage below, in future enrollments, you may be required to provide Evidence of Insurability or be subject to a Late Enrollment penalty.

Life Insurance

- Basic Life with AD&D (Employer Paid)
 Additional Life with AD&D (Member Paid) requested amount \$ _____
 (click on the link for plan details) https://www.standard.com/eforms/20347alaa_643865.pdf

Dependents Life Insurance

- Spouse Life requested amount \$ _____
 Spouse Name _____ Date of Birth _____
 Child(ren) Life requested amount \$ _____

Voluntary Long Term Disability (Member Paid)

(click on the link for plan details) https://www.standard.com/eforms/20351ca_643865.pdf

You must choose one of the following options:

- Option 1 Option 2 Option 3 Option 4 Option 5 Option 6

Accident Insurance (Member Paid)

Elect coverage for:

- You only You and your Spouse You and your Child(ren) (no Spouse) You, your Spouse and Child(ren)

Critical Illness Insurance (Member Paid)

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

You must choose one of the following options:

- Member* requested amount \$30,000
 Spouse requested amount \$30,000

*Eligible child(ren) are automatically covered at 25% of your Coverage Amount.

Return completed form to your Plan Administrator.

Beneficiary This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. <i>if known</i>	Relationship	% of Benefit*
Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. <i>if known</i>	Relationship	% of Benefit*

*Total must equal 100%

For Accident, Critical Illness Insurance:

These benefits are under limited benefit insurance policies. These policies are a supplemental to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxed.

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. I represent that the statements contained herein 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 (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The 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 and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Member Signature Required _____ Date (Mo/Day/Yr) _____
 Enroller (if applicable) _____ Enroller ID _____ Date (Mo/Day/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.

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