Reset

Standard Insurance Company

Enrollment and Change

To Be Completed By DCHR

Group Number	Division	Billing Category	Date of Employment
641332			
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change ***Complete Beneficiary Section on page 2.*** ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete_____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	Gender	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) *Complete only if name change*		Phone Number		
Employer Name **Government of the District of Columbia**	Job Title/Occupation			

Coverage ***Check with DCHR about coverage options available to you and Evidence Of Insurability requirements.***

Plan 1 (basic) Life with AD&D Insurance
☐ 1 times Annual Earnings + $2,000

Plan 2 (optional) Life Insurance
You may elect any or all of the following options, provided you are enrolled in Plan 1 (basic) Life with AD&D Insurance.

Option A – (optional) Life with AD&D Insurance
☐ $10,000

Option B – (optional) Life with AD&D Insurance
You may elect any one of the following options.
☐ 1 times Annual Earnings ☐ 4 times Annual Earnings
☐ 2 times Annual Earnings ☐ 5 times Annual Earnings
☐ 3 times Annual Earnings

Option C – Dependents Life Insurance
You may elect any one of the following options.
☐ Spouse - $10,000 / Child - $10,000
☐ Spouse - $25,000 / Child - $10,000
☐ Spouse - $50,000 / Child - $10,000

Spouse Name_____ Date of Birth_____

Short Term Disability
☐ Voluntary STD

Long Term Disability
☐ Voluntary LTD

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.

Return completed form to DCHR.

Beneficiary ***This designation applies ONLY to Basic Life with AD&D Insurance, if any, available through your Employer. 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. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Beneficiary ***This designation applies ONLY to Optional Life with AD&D Insurance, if any, available through your Employer. 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. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

***Total must equal 100%**

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) _____

Print

Return completed form to DCHR.