Standard Insurance Company

Enrollment and Change Form

Reset

Mark all boxes and complete all sections that apply. Return completed form to your Office of Benefits.

APPLICANT

Your Name (Last, First, Middle)		Group Name **Prince William County Public Schools**	Group Number(s) **645512**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

DISABILITY

Check with your Office of Benefits about coverage options available to you and Evidence Of Insurability requirements.

Long Term Disability/EAP

☐ Voluntary LTD/EAP

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change
Former name _____

☐ Cancel Insurance
☐ Other _____

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)

Office of Benefits - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $_____ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr

Print