



Policy No. 642548

Application for Group LTD Insurance with Standard Insurance Company				
Member: (Last)		(First)	(Middle)	Social Security No.:
Address:		City:	State:	Zip:
Employer:	Email Address:	Work Phone No.:	Home Phone No.:	
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Employer's Address:		City:	State:	Zip:
Employment Date:	Position:	Are you employed on a full-time basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you actively at work full-time on the date of this enrollment?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Check Boxes that Apply:		Monthly Benefit Amount:	Annual Salary:	
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Coverage		\$		
Disability Waiting Period:		<i>Shaded areas for official use only.</i>		
<input type="checkbox"/> 60 <input type="checkbox"/> 120				
Membership with:		Membership Date:	Effective Date:	
<input type="checkbox"/> ACSA <input type="checkbox"/> ACCCA <input type="checkbox"/> District Paid				

If you have never been a member of the Association previously and apply for coverage within 90 days of becoming a member, you are guaranteed to be accepted for certain amounts.

<input type="checkbox"/> I am a new member of the Association and have never previously been a member.	
I want my premium payments:	
<input type="checkbox"/> 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 will change if my coverage or costs change.	
<input type="checkbox"/> I wish to make the choices indicated on this form. If electing coverage, I wish to authorize electronic payment (Credit Card or ACH) to cover my contribution toward the cost of insurance. I understand that my deduction will change if my coverage or costs change. (Please contact plan administrator for electronic authorization forms.)	
Member's Signature:	Date:

Instructions
Medical History Statement is required from the member if applying for more than guaranteed acceptance coverage. Check to see that Enrollment Form and Medical History Statement, if required, are signed before mailing to Mestmaker & Associates. Additional forms are available by calling 1-877-472-6722.