Standard Insurance Company

# Enrollment and Change

## To Be Completed By Human Resources

| Group Number | Division | Billing Category | Date of Employment |
|---|---|---|---|
| **761549** | | | |

## To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

☐ Beneficiary Change ***Complete Beneficiary Section***

| Your Full Name | Social Security Number | Birth Date | |
|---|---|---|---|
| Address | City | State | ZIP |
| Phone Number | Job Title/Occupation | ☐ Male ☐ Female | |
| Employer Name<br>**Hand County** | Hours Worked Per Week | | |

### Coverage

*Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.*

**Life Insurance**

☑ Basic Life with AD&D (Employer Paid)

Your Full Name

**Dental Insurance**

☐ Dental (Employee paid)

Are you or your dependents covered for dental insurance under another plan? ☐ Yes ☐ No

**Eye Care Insurance**

☐ Balanced Eye Care (Employee Paid)

Are you or your dependents covered for eye care insurance under another plan? ☐ Yes ☐ No

***List dependents to enroll or drop for Dental and/or Eye Care, if applicable. (Attach sheet for additional dependents, if needed.)***

| Full Name (Last name if different, First, Middle Initial) | Dental (Employee paid) | | Eye Care (Employee paid) | | Gender | | Date of Birth |
|---|---|---|---|---|---|---|---|
| | Add | Drop | Add | Drop | M | F | |
| Spouse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Child 1 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Child 2 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Child 3 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

**Dental and/or Eye Care Insurance Waiver: Dental and/or Eye Care Insurance**

The insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Entrant Penalty.

I decline ☐ Dental and/or ☐ Eye Care insurance for myself.

I decline ☐ Dental and/or ☐ Eye Care insurance for one or more dependents.

**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 | DOB | Phone No. | SSN *if known* | Relationship | % of Benefit* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Contingent — Full Name | Address | DOB | Phone No. | SSN *if known* | Relationship | % of Benefit* |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

*Total must equal 100%

| Your Full Name |
|---|
| |

**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).

| Signature of Applicant (Member/Employee) | Date |
|---|---|
| | |

**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 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.