Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Class	Date of Employment
163753		**Class 1 Active Members**	

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 **City of Gloucester**	Hours Worked Per Week		
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, 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

You must choose one of the following options:

☐ Life with AD&D (Employee Paid) requested amount $_____

You must choose one of the following options:

☐ Additional Life with AD&D (Employee Paid) requested amount $_____

☐ Decline Additional Life (Employee Paid)

Dependents Life Insurance

☐ Spouse Life with AD&D (Employee Paid) requested amount $_____

Child(ren) Life with AD&D (Employee Paid) ☐ $1,000 ☐ $5,000 ☐ $10,000

Short Term Disability Insurance

You must choose one of the following options:

Short Term Disability (Employee Paid) plan option requested _____

☐ Decline Short Term Disability (Employee Paid)

Long Term Disability Insurance

You must choose one of the following options:

Long Term Disability (Employee Paid) plan option requested _____

☐ Decline Long Term Disability (Employee Paid)

Your Full Name

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. 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%

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.

Signature of Applicant (Member/Employee)	Date