Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
171734			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

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

☐ Reinstatement

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Sabinal Independent School District**	Hours Worked Per Week	Are You Actively At Work? ☐ Yes ☐ No	
Spouse Full Name		Birth Date	

Coverage

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

Accident Insurance

Accident Insurance (Employee Paid)

Choose a plan:

☐ Select ☐ Enhanced

Elect coverage for:

☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and Child(ren)

Critical Illness Insurance

Critical Illness Insurance (Employee Paid)*

☐ Employee* requested amount $_____

☐ Spouse requested amount $_____

*Eligible child(ren) are automatically covered at 50% of your Coverage Amount.

Hospital Indemnity Insurance

Hospital Indemnity Insurance (Employee Paid)

Choose a plan:

☐ Low ☐ High

Elect coverage for:

☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and your Child(ren)

If applying for Hospital Indemnity coverage for your Spouse, is your Spouse gainfully employed or capable of performing the material duties of an occupation? ☐ Yes ☐ No

Your Full Name

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%

For Accident, Critical Illness, Hospital Indemnity Insurance:
These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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

Your Full Name

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.