

To Be Completed By Human Resources

Group Number 161925	Division	Billing Category Class 2 (Call-a-ride operators working 40 or more hours per week)	Date of Employment
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To Be Completed By Applicant Apply for Coverage Name Change Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address	City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name Bi-State Development		Job Title/Occupation	
Hours Worked Per Week			

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***Additional Life Insurance**You **must** choose one of the following options:

- Elect Additional Life \$10,000
 Decline Additional Life \$10,000

Dependents Life InsuranceYou **must** choose one of the following options:

- Elect Spouse Life \$25,000 / Child(ren) Life \$7,000
 Elect Spouse Life \$20,000 / Child(ren) Life \$5,000
 Elect Spouse Life \$10,000 / Child(ren) Life \$2,500
 Decline Spouse Life / Child(ren) Life

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.

If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____