## To Be Completed By Human Resources

| Group Number | Division | Billing Category | Date of Employment |
|---|---|---|---|
| **161925** | | **Class 4 (IBEW Locals #2 and #309)** | |

## 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 | ☐ Male ☐ Female | |
|---|---|---|---|---|
| Your Address | | City | State | ZIP |
| Former Name (Last, First, Middle) *Complete only if name change* | | | 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.***

**Dependents Life Insurance**

*You **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) _____

***Return completed form to your Human Resources Department.***