Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
161925		**Class 1 (Active Full-salaried Members)**	

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.***

Additional Life Insurance

*You **must** choose one of the following options:*

☐ Elect Additional Life 0.5x Annual Earnings

☐ Elect Additional Life 1.0x Annual Earnings

☐ Elect Additional Life 2.0x Annual Earnings

☐ Decline Additional Life

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.