Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources (if applicable)

Group Number	Division	Billing Category	Date of Employment
753117			

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 **Jackson County School District 549c dba Medford School District**	Hours Worked Per Week		
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			
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.

Life Insurance

☑ Basic Life with AD&D (Employer Paid)

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

Dependents Life Insurance

☑ Spouse Life $1,000 / Child(ren) Life $1,000 (Employer Paid)

Additional Dependents Life Insurance

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

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

Short Term Disability Insurance

☐ Short Term Disability (Employee Paid)

Long Term Disability Insurance

☑ Long Term Disability (Employer 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