Standard Insurance Company

Enrollment and Change
Oregon

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 _____

☐ Reinstatement

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	Are You Actively At Work? ☐ Yes ☐ No	
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. If you choose not to elect any coverage below, in future enrollments, you may be required to provide Evidence of Insurability or be subject to a Late Enrollment penalty.

Accident Insurance

Accident Insurance (Employee Paid)

You must choose one of the following options:

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

☐ Decline Accident (Employee Paid)

Your Full Name

Critical Illness Insurance

Critical Illness Insurance (Employee Paid)*

You must choose one of the following options:

☐ Employee* requested amount $15,000

☐ Decline Critical Illness (Employee Paid)

You must choose one of the following options:

☐ Spouse requested amount $15,000

☐ Decline Critical Illness for your Spouse (Employee Paid)

Eligible child(ren) are automatically covered at 25% of your Coverage Amount. **If the coverage option you select requires Evidence Of Insurability, please complete the questions below for you and/or your Spouse.**	You		Spouse	
	Yes	No	Yes	No
1. In the past 12 months have you or your Spouse had any symptom or been informed by a medical professional of any abnormal test result which resulted in a recommendation to have any diagnostic test or procedure which has not yet been completed?	☐	☐	☐	☐
2. Has a medical professional ever diagnosed you or your Spouse as having or prescribed medication for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) antibodies?	☐	☐	☐	☐
3. In the past 10 years, have you or your Spouse had, been treated for or been diagnosed by a medical professional as having: • diabetes (other than during pregnancy); heart disorder; angina; arterial disease; heart attack; angioplasty; coronary artery bypass; high blood pressure (hypertension) treated with three (3) or more medications; rheumatic fever; stroke; transient ischemic attack; • renal disease (excluding kidney stone or urinary tract infection); pancreas disorder; liver cirrhosis; hepatitis (excluding hepatitis A); • benign brain tumor; systemic lupus; muscular dystrophy; poliomyelitis; osteomyelitis or neurological disorder; • Addison's disease; sickle cell anemia; hemophilia; paralysis; organ transplant; tuberculosis; or lung disease (excluding asthma or acute pneumonia);	☐	☐	☐	☐
4. In the past 10 years, have you or your Spouse had, been treated for or been diagnosed by a medical professional as having cancer or malignancy (excluding non-melanoma skin cancer); bone marrow disorder, ulcerative colitis or Crohn's disease?	☐	☐	☐	☐

For Accident, Critical Illness 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, including, if applicable, those made in response to the Evidence Of Insurability questions, 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