Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
644048			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ 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 **City of Defuniak Springs**			Job Title/Occupation	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

☒ Basic Life with AD&D (Employer Paid)

You may choose one of the following options for yourself:

☐ Additional Life requested amount $_____

☐ Additional Life with AD&D requested amount $_____

Dependents Life Insurance

☐ Spouse Life requested amount $_____ Spouse Name_____ Date of Birth_____

☐ Child(ren) Life $5,000

Dental/Vision

☐ Voluntary Dental ☐ Voluntary Balanced Care Vision

Coverage requested for Dental ☐You, your Spouse & Children ☐You & your Spouse ☐ You only ☐You & your Children (no Spouse)

Coverage requested for Vision ☐You, your Spouse & Children ☐You & your Spouse ☐ You only ☐You & your Children (no Spouse)

Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more dependents? ☐ Yes ☐ No

List dependents to enroll or delete for Dental/Vision, if applicable (Attach sheet for additional dependents, if needed).

Spouse Full Name	SSN	☐Male ☐Female	Birth Date
Child 1 Full Name	SSN	☐Male ☐Female	Birth Date
Child 2 Full Name	SSN	☐Male ☐Female	Birth Date
Child 3 Full Name	SSN	☐Male ☐Female	Birth Date

Beneficiary ***This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

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.

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

Return completed form to your Human Resources Department.