Standard Insurance Company

Enrollment and Change
California

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
169596	**Employees Not Enrolled in LTD Under Prior Carrier**		

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **City of Ceres**	Hours Worked Per Week		
Earnings $ _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Long Term Disability Insurance

☐ Long Term Disability (Employee Paid)

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 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