Standard Insurance Company

Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)	Group Name		Group Number(s)
	Leon County Board of County Commissioners		**148342**
Your Address	City	State	ZIP

Your Soc. Sec. No.	Date of Birth		Job Title/Occupation
		☐ Male ☐ Female	

DISABILITY

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

Long Term Disability

You must choose one from the following plan options.

☐ 90 Day Benefit Waiting Period ☐ 180 Day Benefit Waiting Period ☐ Decline Long Term Disability

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change Former name ______________________ ☐ Other ________________________

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)

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $______________ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr