Standard Insurance Company

Enrollment and Change

To Be Completed By Benefits Office

Group Number	Date of Employment
155117	

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	Job Title/Occupation
Shawnee Mission School District	

Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Coverage *Check with your Benefits Office about coverage options available to you and Evidence Of Insurability requirements.*

Life Insurance

☐ Voluntary Life with AD&D Current Life amount $_____ Requested Life amount $_____

Dependents Life Insurance

☐ Spouse Life Current Life amount $_____ Requested Life amount $_____

Spouse Name_____ Date of Birth_____

☐ Child(ren) Life Current Life amount $_____ Requested Life amount $_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

Child Name_____ Date of Birth_____

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 & DOB	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name & DOB	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 Benefits Office.