Standard Insurance Company

Enrollment and Change Form

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

MEMBER INFORMATION

Enrollment
- ☐ Initial Enrollment
- ☐ Rehire/Reinstatement

Change
- ☐ Add Dependent
- ☐ Beneficiary Change
- ☐ Delete Dependent
- ☐ Address Change
- ☐ Date of add/delete_____
- ☐ Name Change
- ☐ Other_____

Group Name	Group Number	Division ID	
City of San Clemente	**140232**		
Your Name (Last, First, Middle)	If Name Change, What Was Your Former Name?	Soc. Sec. No.	
Your Address	City	State	ZIP
Date Of Birth	☐ Male ☐ Female	Earnings $	Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr
Date Of Hire	Hours Worked Per Week	Job Title/Occupation	

COVERAGE SECTION

Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.

1. **Basic Life**

☒ Basic Life with AD&D - Employer Paid

2. **Additional Life and Additional AD&D for Members**

You may elect to enroll in either Additional Life or Additional Life with matching AD&D in increments of $10,000, from $10,000 to a maximum of $500,000 or 5x your Annual Earnings rounded to the lower multiple of $10,000, whichever is less.

☐ Additional Life — Employee requested amount $_____

☐ Additional Life and AD&D

3. **Additional Life and Additional AD&D for Spouse/Domestic Partner (DP)**

You may elect to insure your Spouse or DP if you elect Additional Life coverage. You may elect Additional Life or Additional Life with matching AD&D coverage in $5,000 increments from $5,000 to $500,000. Coverage may not exceed 100% of your amount.

☐ Spouse Additional Life — Spouse requested amount $_____

☐ Spouse Additional Life and AD&D — Spouse Name: _____ Date of Birth: _____

4. **Additional Life and Additional AD&D for Child (ren)**

You may elect to insure your eligible Children under one of the following benefit options. If you elect Child Additional Life with AD&D, the amount of AD&D coverage will match the Child Life Additional Life amount.

☐ Child Additional Life ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

☐ Child Additional Life / AD&D

BENEFICIARY

This designation applies to Coverage Section 1 coverage above. Unless specified otherwise on a separate sheet of paper, this Designation will also apply to Coverage Section 2 coverage above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary 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 apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. 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 Signature Required	Date (Mo/Day/Yr)