

# Basic Life Enrollment Form

Standard Insurance Company

**Enrollment and Change**

**To Be Completed By Human Resources**

Group Number <b>146412</b>	Division	Billing Category	Date of Employment
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**To Be Completed By Applicant**     Apply for Coverage

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State    ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name <b>City of Wichita</b>		Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

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

*For City of Wichita internal use.*

Elect Basic – Single     Elect Basic – Family

**Life Insurance**

Life with AD&D

**NOTE: You must elect Basic Life insurance in order to elect Dependents Life insurance.**

**Dependents Life Insurance**

*If you elect Additional Life insurance for yourself, you may elect coverage for your spouse and/or child(ren).*

Spouse Life \$4,000

Child(ren) Life \$4,000

**Beneficiary** *This designation applies to all Life Insurance available through your Employer. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 3 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) \_\_\_\_\_

# Additional Life Enrollment Form

Standard Insurance Company

**Enrollment and Change**

**To Be Completed By Human Resources**

Group Number <b>146412</b>	Division	Billing Category	Date of Employment
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**To Be Completed By Applicant**     Apply for Coverage

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name <b>City of Wichita</b>			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

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

**NOTE: You must elect Basic Life insurance in order to elect Additional/Optional Life insurance.**

**Additional/Optional Life Insurance**

*You may choose one of the following coverage amounts:*

Additional/Optional Life     1x Annual Earnings     2x Annual Earnings     3x Annual Earnings     4x Annual Earnings

See page 1 of this form for Beneficiary election for all Life products.

**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.*

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.