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 **Government of the District of Columbia**	Group Number(s) **641332**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

DISABILITY

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

Short Term Disability

☐ Voluntary STD

Long Term Disability

☐ Voluntary LTD

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.

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