Reset

Standard Life Insurance Company of New York **Enrollment and Change Form**

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

APPLICANT

Your Name (Last, First, Middle)	Group Name	Group Number(s)	
Your Address	City	State	Zip
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation

COVERAGE SECTION

For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept.

1. Life Insurance
☐ Life ☐ Life with AD&D Employer paid amount $_____
☐ Additional/Optional Life ☐ Additional/Optional Life with AD&D Your requested amount $_____

2. Voluntary Life Insurance
☐ Voluntary Life ☐ Voluntary Life with AD&D Your requested amount $_____

3. Dependents Life Insurance
☐ Life ☐ Life with AD&D Employer paid amount $_____
☐ Spouse requested amount $_____ Spouse Name _____ Date of Birth _____
☐ Children requested amount $_____

4. Supplemental Life Insurance
☐ Supplemental Life Your requested amount $_____ Spouse requested amount $_____

5. Short Term Disability ☐ Employer Paid ☐ Enhanced (Buy-up) ☐ Voluntary STD

6. Long Term Disability ☐ Employer Paid ☐ Enhanced (Buy-up) ☐ Voluntary LTD ☐ MAPB

7. Dental *(See below)* ☐ Employer Paid ☐ High Plan ☐ Voluntary Dental

DENTAL

Marital Status ☐ Single ☐ Married ☐ Divorced
Coverage requested for ☐ You, your Spouse and Children ☐ You and your Spouse ☐ You only ☐ You and your Children (no Spouse)
Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more Dependents? ☐ Yes ☐ No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

Dental Insurance Waiver: Contributory Dental Insurance
The Dental Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Dental Insurance coverage may be subject to a Late Enrollment Penalty.
☐ I decline Dental Insurance for myself ☐ I decline Dental Insurance for one or more Dependents

BENEFICIARY

This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 2 above. Unless specified otherwise on a separate sheet, this designation will also apply to coverage available through your Employer, if any, under Coverage Section 4 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent – Full Name	**Address**	**Soc. Sec. No.**	**Relationship**	**% of Benefit**

CHANGE

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

☐ Add Dependent ☐ Delete Dependent ☐ Name Change ☐ Beneficiary Change
Date of add/delete _____ 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.

Fraud Notice – Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

HR Dept. – 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

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.

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