

Standard Life Insurance Company		Enrollment and Change Form		
To Be Completed By Human Resources				
Group Number 153964	Division	Billing Company	Date of Employment	
To Be Completed By Applicant <input type="checkbox"/> Apply for Coverage <input type="checkbox"/> Beneficiary Change Complete Beneficiary Section below. <input type="checkbox"/> Add or <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Date of add/delete _____				
Your Name (Last, First, Middle)	Your Social Security Number	Date of Birth	Age:	<input type="checkbox"/> Female <input type="checkbox"/> Male
Your Address	City	State	Zip	
Former Name (Last, First, Middle)	Phone Number			
Employer Name	Job Title/Occupation			
Bay County Board of County Commissioners				
Hours Worked Per Week _____	Monthly Income \$ _____ (annual divided by 12)			
Coverage: Check with your Human Resources Department about coverage options available to you and Evidence of Insurability requirements Long Term Disability <i>You may choose one of the following options</i> <input type="checkbox"/> Elect Voluntary LTD (90-Day Plan) Monthly Rate: \$ _____ <input type="checkbox"/> Elect Voluntary LTD (180-Day Plan) Monthly Rate: \$ _____ <input type="checkbox"/> Decline Voluntary LTD				
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 _____	

Return Completed form to your Human Resources Department.