The 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 **Ravena Coeyman Selkirk Central District School**	Group Number(s) **430584**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

LIFE

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

Life Insurance

☒ Life with AD&D Employer Paid

BENEFICIARY

This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. 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 of 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