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 **Idaho State Board of Education**	Group Number(s) **136304**	
	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 specific options available to you and Evidence of Insurability requirements.

Long Term Disability

Voluntary LTD MAPB (monthly annuity premium benefit)

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.	
0001				Earnings $______________Per: Hour Wk Mo Yr