Standard Insurance Company

Enrollment and Change
Montana

To Be Completed By Human Resources (if applicable)

Group Number	Division	Billing Category	Date of Employment
165720			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

☐ Reinstatement ☐ Beneficiary Change ***Complete Beneficiary Section***

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Diocese Of Helena**	Hours Worked Per Week	Are You Actively At Work? ☐ Yes ☐ No	
Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			
Have you or your Spouse used tobacco in any form in the last 12 months? You: ☐ Yes ☐ No Your Spouse: ☐ Yes ☐ No			
Spouse Full Name		Birth Date	

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements. If you choose not to elect any coverage below, in future enrollments, you may be required to provide Evidence of Insurability or be subject to a Late Enrollment penalty.

Life Insurance

☑ Basic Life with AD&D (Employer Paid)

You must choose one of the following options:

☐ Additional Life (Employee Paid) requested amount $_____

☐ Decline Additional Life (Employee Paid)

Dependents Life Insurance

You must choose one of the following options for your Spouse:

☐ Spouse Life (Employee Paid) requested amount $_____

☐ Decline Spouse Life (Employee Paid)

You must choose one of the following options for your Child(ren):

☐ Child(ren) Life (Employee Paid) requested amount $10,000

☐ Decline Child(ren) Life (Employee Paid)

Long Term Disability Insurance

☑ Long Term Disability (Employer Paid)

Your Full Name

Accident Insurance

Accident Insurance (Employee Paid)
You must choose one of the following options:
☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and Child(ren)
☐ Decline Accident (Employee Paid)

Critical Illness Insurance

Critical Illness Insurance (Employee Paid)*
You must choose one of the following options:
☐ Employee* requested amount $_____
☐ Decline Critical Illness (Employee Paid)

You must choose one of the following options:
☐ Spouse requested amount $_____
☐ Decline Critical Illness for your Spouse (Employee Paid)

Eligible child(ren) are automatically covered at 25% of your Coverage Amount.

If the coverage option you select requires Evidence Of Insurability, please complete the questions below for you and/or your Spouse.

	You		Spouse	
	Yes	No	Yes	No
1. In the past 12 months have you or your Spouse had any symptom or been informed by a medical professional of any abnormal test result which resulted in a recommendation to have any diagnostic test or procedure which has not yet been completed?	☐	☐	☐	☐
2. Has a medical professional ever diagnosed you or your Spouse as having or prescribed medication for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) antibodies?	☐	☐	☐	☐
3. In the past 10 years, have you or your Spouse had, been treated for or been diagnosed by a medical professional as having: • diabetes (other than during pregnancy); heart disorder; angina; arterial disease; heart attack; angioplasty; coronary artery bypass; high blood pressure (hypertension) treated with three (3) or more medications; rheumatic fever; stroke; transient ischemic attack; • renal disease (excluding kidney stone or urinary tract infection); pancreas disorder; liver cirrhosis; hepatitis (excluding hepatitis A); • benign brain tumor; systemic lupus; muscular dystrophy; poliomyelitis; osteomyelitis or neurological disorder; • Addison's disease; sickle cell anemia; hemophilia; paralysis; organ transplant; tuberculosis; or lung disease (excluding asthma or acute pneumonia);	☐	☐	☐	☐
4. In the past 10 years, have you or your Spouse had, been treated for or been diagnosed by a medical professional as having cancer or malignancy (excluding non-melanoma skin cancer); bone marrow disorder, ulcerative colitis or Crohn's disease?	☐	☐	☐	☐
5. In the past 10 years, have you or your Spouse had, been treated for or been diagnosed by a medical professional as having: glaucoma; retinitis pigmentosa or macular degeneration?	☐	☐	☐	☐

Your Full Name

Dental Insurance

☑ Dental (Employer paid)

Are you or your dependents covered for dental insurance under another plan? ☐ Yes ☐ No

Eye Care Insurance

☑ Eye Care (Employer Paid)

Are you or your dependents covered for eye care insurance under another plan? ☐ Yes ☐ No

List dependents to enroll or drop for Dental and/or Eye Care, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Dental (Employee paid)		Eye Care (Employee paid)		Gender		Date of Birth
	Add	Drop	Add	Drop	M	F	
Spouse	☐	☐	☐	☐	☐	☐	
Child 1	☐	☐	☐	☐	☐	☐	
Child 2	☐	☐	☐	☐	☐	☐	
Child 3	☐	☐	☐	☐	☐	☐	

Dental and/or Eye Care Insurance Waiver: Dental and/or Eye Care Insurance

The 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 insurance coverage may be subject to a Late Entrant Penalty.

I decline ☐ Dental and/or ☐ Eye Care insurance for myself.

I decline ☐ Dental and/or ☐ Eye Care insurance for one or more dependents.

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. This designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*
Contingent — Full Name	Address	DOB	Phone No.	SSN *if known*	Relationship	% of Benefit*

*Total must equal 100%

Your Full Name

For Accident, Critical Illness Insurance:
These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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. I represent that the statements contained herein, including, if applicable, those made in response to the Evidence Of Insurability questions, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee)	Date

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 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.