Standard Insurance Company **Basic Life** **Enrollment and Change Form**

Mark all boxes and complete all sections that apply. Return completed form to your Employee Benefits Department.

APPLICANT

Your Name (Last, First, Middle)		Group Name	Group Number(s)	
		City of Spokane	**399122**	
Your Address		City	State	Zip
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

Have you or your spouse used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

OFFICE USE ONLY

Check with your employee Benefits Department about coverage options available to your and Evidence of Insurability requirements.

Voluntary Life

☐ Voluntary Life Your requested amount $ _____

Dependents Life Insurance

☐ Spouse requested amount $ _____ Spouse Name _____ Date of Birth _____

☐ Children requested amount $

BENEFICIARY

This designation applies to Life 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 Benefits

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefits

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. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

Member/Employer Signature Required	Date (Mo/Day/Yr)

Employee Benefits Department - 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 ina 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 legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust mut be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the truse 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.

Fraud Notices

FOR RESIDENTS OF AR, DC, KY LA, ME NM, OH, TN: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

FOR RESIDENTS OF CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FOR RESIDENTS OF NY: 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 act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FOR RESIDENTS OF PA: 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 subjects such person to criminal and civil penalties.