LONG TERM DISABILITY

Group Insurance Enrollment Form — *Please Print* — *Standard InsuranceCo. Portland, OR*

Group Number 0001	*Suffix*	*Group Name* Thompson School District	*Social Security Number*

Member Name (Last, First, M.I.	☐ *Male* ☐ *Female*	*Birthday Month/Day/Yr* / /

Date Employed Month/Day/Year	*Workplace Location (State)*	*Coverage(s) Applying for: LTD* ☐	*Eff. Date of Ins. Month/Day/Yr* / /

Occupation	*Hours Worked Each Week for This Employer (not incl. overtime)* _____	*Base Earnings from This Employer* $_____ ☐ *Hr.* ☐ *Wk* ☐ *Mo.* ☐ *Yr.*

Beneficiary – Complete for Life & ADD&D Insurance
Full Name, Address & Social Security Number — *Relationship*

_____ _____
_____ _____
_____ _____

I apply for insurance under the Group Insurance Plan. I authorize deductins from my wages to cover my contribution, if required, toward the cost of my insurance.

_____ _____
Signature — *Date*

Note: Beneficiary designation is not valid unless the card is signed & dated.