Standard Insurance Company Enrollment and Change Form

Mark all boxes and complete all section that apply. Return completed form to Human Resources.

APPLICANT

Name (Last, First, MI):	Group: **Carteret County Government (Class 2)**	Group Number: **142794**	
Address:	City:	State:	Zip:
Soc. Sec. Number:	Date of Birth:	☐ Male	☐ Female	Job Title:

LIFE INSURANCE

Check with your Human Resources Department about coverage options available to you and Evidence of Insurability requirements.

☐ Life Insurance Employer Paid

☐ Additional/Optional Life with AD&D | Requested amount $

You must elect Additional/Optional Life with AD&D to be eligible to elect Spouse/Children Life with AD&D.

☐ Spouse Life with AD&D | Requested amount $

Spouse Name: | Date of Birth:

☐ Children Life with AD&D | Requested amount $

BENEFICIARY

This designation applied to Life Insurance available through your employer, if any. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Accidental Death & Dismemberment (AD&D) Insurance available through your employer, if any. Designations are not valid unless signed, dated and delivered to the employer during your lifetime. Additional beneficiaries may be listed on a separate sheet of paper.

Primary - Full Name:	SSN:	Relation:	%:
Address:	City:	State:	Zip:
Primary - Full Name:	SSN:	Relation:	%:
Address:	City:	State:	Zip:

Contingent - Full Name:	SSN:	Relation:	%:
Address:	City:	State:	Zip:
Contingent - Full Name:	SSN:	Relation:	%:
Address:	City:	State:	Zip:

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 | ☐ Other

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, age or cost change.

Employee Signature: | Date:

HR

Dept. # | Date of Hire/Rehire: | Hours Worked per Week:

Earnings $ | Per ☐ Hour ☐ Week ☐ Month ☐ Year