

To Be Completed By Human Resources

Group Number 643908	Division	Billing Category	Date of Employment
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To Be Completed By Applicant Apply for Coverage Name Change

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name Gallaudet University		Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

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

Long Term Disability

Elect Voluntary LTD Decline Voluntary LTD

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.

If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____