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Standard Insurance Company
Small Business Service and Risk, 900 SW Fifth Avenue Portland OR 97204

# Enrollment and Change Form

***Check all boxes and complete all sections that apply. Return completed form to your employer.***

## APPLICANT

| Your Name (Last, First, Middle) | Group Name | Group Number(s) | |
|---|---|---|---|
| | **Paddle Palace, Inc.** | **ST910827** | |
| Your Address | City | State | Zip |
| | | | |
| Your Soc. Sec. No. | Date of Birth | ☐ Male ☐ Female | Job Title/Occupation |
| | | | |

## COVERAGE SECTION

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

1. ☐ **Life Insurance with AD&D Insurance**
2. ☐ **Dependents Life Insurance**
3. ☐ **Short Term Disability Insurance**
4. ☐ **Long Term Disability Insurance**
5. ☑ **Dental Insurance** *(See below)*

## DENTAL

Marital Status ☐ Single ☐ Married ☐ Divorced
Coverage requested for ☐ You and 2 or more dependents ☐ You and one dependent ☐ You only
Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more dependents? ☐ Yes ☐ No

| *List dependents to enroll or delete.* (Last name if different, First, Middle Initial) | Sex M | Sex F | Date of Birth | *List dependents to enroll or delete.* (Attach sheet for additional dependents if needed.) | Sex M | Sex F | Date of Birth |
|---|---|---|---|---|---|---|---|
| Spouse | | | | Child 2 | | | |
| Child 1 | | | | Child 3 | | | |

**Dental Insurance Waiver: Contributory Dental Insurance**
The Dental 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 Dental Insurance coverage may be subject to a Late Enrollment Penalty.
☐ I decline Dental Insurance for myself ☐ I decline Dental Insurance for one or more Dependents

## BENEFICIARY

*This designation applies to coverage available through your Employer, if any, under Coverage Section 1 above. 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 Benefit |
|---|---|---|---|---|
| | | | | |
| | | | | |
| **Contingent – Full Name** | **Address** | **Soc. Sec. No.** | **Relationship** | **% of Benefit** |
| | | | | |
| | | | | |

## 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
Date of add/delete _____

☐ Name Change
Former name _____

☐ Beneficiary Change
☐ 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.

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

***Employer – Complete this section. Send this form to the address above and retain a photocopy for your records.***

| Division ID | Billing Category | Date of Hire or Rehire | Hours Worked Per Week | 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 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.

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