Standard Insurance Company

Open Enrollment & New Hire

Enrollment and Change

To Be Completed By Applicant ☐ Apply for Coverage ☐ Change in Coverage ☐ Name Change

Employer Name	Group Number	Date of Employment	Job Title/Occupation
Florida Atlantic University	**648969**		

Your Name (Last, First, Middle)			
Employee ID	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Hours Worked Per Week	Annual Earnings $_____	Choose one: I am employed on a ☐ 9 ☐ 10 ☐ 12 month contract

Coverage

Short Term Disability (STD) and Long Term Disability (LTD) Insurance

☐ 30 Day Plan (Voluntary STD and Voluntary LTD)

Long Term Disability Insurance

☐ 90 Day Plan (Voluntary LTD)

The 30 Day (STD and LTD) and 90 Day (LTD) Disability Plans have a pre-existing condition limitation. If I have received medical or surgical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, taken prescribed drugs or medicines, or consulted with a physician or other licensed medical professional, for any mental or physical condition which was discovered or suspected as a result of any routine or other medical examination at any time within the 90 days prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. Review your booklet for additional information about the effective date of your coverage and the pre-existing condition exclusion.

Signature: I wish to make the choices indicated on this form. 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) _____

Return completed form to your Human Resources Department.