

*Please mark all boxes, complete all sections that apply, and return to your Human Resources Representative. Be sure to sign and date your Enrollment and Change form.*

*During your annual enrollment period, you may elect to discontinue your participation in this plan each annual enrollment period with an effective date of July 1<sup>st</sup> of each year.*

*Note: You may also enroll online at [www.standard.com/enroll](http://www.standard.com/enroll).*

*Human Resources Representative, complete the last section and return completed form to The Standard by fax (888) 644-6814.*

APPLICANT	Your Name (Last, First, Middle)		Group Name <b>State of Utah</b>	Employee/Member ID No.	Group Number(s) <b>646597</b>	
	Your Address			City	State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title/Occupation		
DISABILITY	<b>Short Term Disability</b> Voluntary STD <input type="checkbox"/> Option 1: 7 Day Waiting Period <input type="checkbox"/> Option 2: 30 Day Waiting Period					
CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Name Change      Former name _____ <input type="checkbox"/> 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)	
<b>Human Resources - Complete this section. Retain form for your records.</b>						
Dept #	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	