Standard Insurance Company

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability (LTD)
Enrollment and Change Form

To Be Completed By Employee

☐ Apply for Coverage ☐ Name Change

Your Name (Last, First, Middle)		Your Social Security Number	Birth Date	Employee I.D. Number	
Your Address			City	State	Zip Code
Former Name (Last, First, Middle) *Complete only if you are reporting a name change*			Phone Number	☐ Male ☐ Female	
Agency Name	Agency Code		Job Title/Occupation		
Hours Worked Per Week	Earnings $____________ Per: ☐ Hour ☐ Week ☐ Month ☐ Year				

Long Term Disability (LTD) Insurance Coverage

I wish to:

☒ Enroll in basic LTD (Employer Paid)

☐ Enroll in supplemental LTD (Employee Paid) (90 day waiting period before coverage begins)

☐ Cancel my supplemental LTD coverage

If you request supplemental LTD coverage after 31 days of becoming newly eligible for SEBB coverage, you must also complete the LTD Evidence of Insurability form and send it to Standard Insurance Company (The Standard) at 900 SW 5th, Portland, OR 97204-1282 or call 1-800-368-2860.

To Be Completed By Employee's Payroll or Benefits Office Staff

Employer Name		Group Number	Effective Date of Coverage *(if no approval required)*
WA Heath Care Authority School Employees Benefits Board (SEBB) Program		**756494**	
Current Agency Hire Date	Initial Eligibility Date for SEBB Benefits	Employee's Current Coverage ☐ basic LTD ☐ supplemental LTD – waiting period 90 days	

Signature I wish to make the choices selected 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.

This form replaces all previous forms and submissions I have made for SEBB Program's Long term disability coverage.

Employee Signature Required ____ Date (Mo/Day/Yr) ________________

Return completed form to your payroll or benefits office.