Standard Insurance Company

Additional Life/AD&D Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to the Career Service Authority.

APPLICANT

Your Name (Last, First, Middle)	Group Name: **City and County of Denver**	Group Number(s): **615855**
Your Address	City	State / ZIP
Your Soc. Sec. No. / Date Of Birth	☐ Male ☐ Female	Job Title/Occupation

Have you or your spouse used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

LIFE

Check with the Career Service Authority about coverage options available to you.

Please see the instructions on page 2 regarding Evidence Of Insurability requirements.

Additional Life

☐ Additional/Optional Life Your requested amount $_______________

Dependents Life Insurance

☐ Spouse requested amount $__________ Spouse Name______________________________ Date of Birth___________

☐ Children requested amount ☐ $5,000 ☐ $10,000

Accidental Death and Dismemberment (AD&D) Insurance

☐ Voluntary AD&D Your requested amount $_______________ ☐ Employee Only ☐ Employee/Children ☐ Employee/Spouse ☐ Employee/Spouse/Children

BENEFICIARY

This designation applies to Additional Life Insurance only. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Voluntary Accidental Death and Dismemberment (AD&D) Insurance available through your Employer. Your current Basic Life Insurance beneficiary designation continues to be valid. If you wish to change your Basic Life Insurance beneficiary designation please make this change on the Basic Life Insurance beneficiary change form. 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 ☐ Name Change ☐ Beneficiary Change

Date of add/delete ___________________ Former name _____________________ ☐ 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. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

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

Evidence of Insurability Requirements (EOI)

You and/or your dependents are required to submit EOI if you answer true to any one of the following statements. If you answer true, you and/or each of your dependents will be required to complete a Medical History Statement (MHS). Medical History Statements can be obtained from the Career Service Authority or at www.denvergov.org.

1. I am requesting Additional Life coverage in excess of $100,000 for the first time.
   - ☐ True – You complete a MHS
   - ☐ False
2. I am requesting Additional Life coverage in excess of a previously approved amount of Additional Life insurance over $100,000 (i.e. previously approved for $150,000, now requesting $200,000).
   - ☐ True – You complete a MHS
   - ☐ False
3. I am requesting Dependent Life insurance for my spouse in excess of $30,000 for the first time.
   - ☐ True – Your spouse completes a MHS
   - ☐ False
4. I am requesting Dependent Life insurance for my spouse in excess of a previously approved amount of Dependent Life insurance over $30,000 (i.e. previously approved for $40,000, now requesting $45,000).
   - ☐ True – Your spouse completes a MHS
   - ☐ False
5. I am requesting coverage more than 31 days after becoming an eligible member.
   - ☐ True – You complete a MHS
   - ☐ False
6. I am requesting coverage for my spouse and/or my dependent children more than 31 days after they become an eligible dependent.
   - ☐ True – Your spouse and/or dependent children complete a MHS
   - ☐ False

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 any 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.

Fraud Notice

FOR RESIDENTS OF CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.