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Standard Insurance Company
CSU Benefits Team, 900 SW 5th Ave., Portland, OR 97204

Enrollment and Change

Vol. Trust Life-VT 101770-A/ Vol. AD&D-648371-A/ Vol. LTD-648379-A/
Accident Insurance 758442/ Critical Illness Insurance 758443

Check with your plan administrator, or call The Standard at 800.378.5745, if you have any questions concerning the coverage options that apply to your group. Please mail completed form to the address above.

To Be Completed By Member *Check all boxes and complete all sections that apply.*

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Spouse/Domestic Partner (Last, First, Middle)	Spouse Social Security Number	Spouse Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP	Phone Number

Employer Name	Job Title/Bargaining Unit	Campus
The California State University		

Date of Hire	Hours Worked Per Week	Earnings $_____
	Are You Actively At Work? ☐ Yes ☐ No	Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No

Has your Spouse used tobacco in any form in the last 12 months? ☐ Yes ☐ No

Change *Use this section only when you wish to make a change after insurance becomes effective.*

☐ Beneficiary Change *(Use Beneficiary Section Below)* ☐ Name Change Former name _____

☐ Add or ☐ Delete Dependent Date of marriage _____ Date of domestic partnership filing _____

Date of birth/adoption _____

Coverage *Check with your plan administrator or call The Standard at 800.378.5745 about Evidence Of Insurability requirements.*

Voluntary Life Insurance VT-101770-A *See brochure for increments and amounts available.*

☐ Employee requested amount $_____ ☐ Spouse/Domestic Partner requested amount $ _____

☐ Child(ren) ☐ $5,000 ☐ $10,000 ☐ $20,000

Child(ren) Name(s) and Date(s) of Birth_____

Voluntary Accidental Death and Dismemberment (AD&D) Insurance Group No. 648371-A *See brochure for amounts available.*

☐ Employee only requested amount $_____ ☐ Employee and Dependents requested amount $ _____

Child(ren) Name(s) and Date(s) of Birth _____

Voluntary Long Term Disability 648379 *See brochure for amounts available.*

Requested amount $_____ *Check one of the following, if eligible:* Benefit Waiting Period ☐ 30-days ☐ 90-days

Accident Insurance 758442 *Enrollment can only be made during new hire or designated Annual Enrollment period.*

☐ You only ☐ You and Your Spouse/Domestic Partner ☐ You and your Child(ren) (no Spouse/Domestic Partner)

☐ You, your Spouse/Domestic Partner and your Child(ren)

Critical Illness Insurance 758443 *Enrollment can only be made during new hire or designated Annual Enrollment period.*

A.) Do you have major medical or other minimum essential insurance that provides medical, hospital and surgical coverage?

(If the answer is "No", you are not eligible for Critical Illness Insurance.) ☐ Yes ☐ No

B.) Are you age 65 or older? (If you answer "Yes", you are not eligible for Critical Illness.) ☐ Yes ☐ No

☐ Employee* requested amount $_____ *See brochure for amounts available.*
☐ Spouse/Domestic Partner requested amount $_____ *See brochure for amounts available.*

**Eligible child(ren) are automatically covered at 50% of your Coverage Amount.*

Beneficiary ***This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. This designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Total must equal 100%

For Accident and Critical Illness Insurance:
These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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, including, if applicable, those made in response to the Evidence Of Insurability questions, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee) _____ Date (Mo/Day/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 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.

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