Standard Insurance Company

Enrollment and Change
California

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
148627			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

☐ Reinstatement

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **City of Fullerton**	Hours Worked Per Week	Are You Actively At Work? ☐ Yes ☐ No	
Spouse Full Name		Birth Date	

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements. If you choose not to elect any coverage below, in future enrollments, you may be required to provide Evidence of Insurability or be subject to a Late Enrollment penalty.

Accident Insurance

Accident Insurance (Employee Paid)

You must choose one of the following options:

☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and Child(ren)

☐ Decline Accident (Employee Paid)

Critical Illness Insurance

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.) ☐ Yes ☐ No

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

Critical Illness Insurance (Employee Paid)*

You must choose one of the following options:

Employee* requested amount ☐ $10,000 ☐ $20,000

☐ Decline Critical Illness (Employee Paid)

You must choose one of the following options:

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

☐ Decline Critical Illness for your Spouse (Employee Paid)

*Eligible child(ren) are automatically covered at 25% of your Coverage Amount.

Your Full Name

Hospital Indemnity Insurance

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 Hospital Indemnity.) ☐ Yes ☐ No

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

Hospital Indemnity Insurance (Employee Paid)

You must choose one of the following options:

☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and your Child(ren)
☐ Decline Hospital Indemnity (Employee Paid)

If applying for Hospital Indemnity coverage for your Spouse, is your Spouse gainfully employed or capable of performing the material duties of an occupation? ☐ Yes ☐ No

For Accident, Critical Illness, Hospital Indemnity 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
Enroller (If applicable)	Enroller ID	Date (Mo/Day/Yr)