

Public Employees Benefits Board (PEBB) Program
Underwritten by Standard Insurance Company

**Long Term Disability (LTD)
Enrollment/Change Form**

Employees	Personnel, payroll, or benefits office staff
<ul style="list-style-type: none"> Type or print clearly in ink. If you do not wish to enroll in optional LTD coverage, complete Sections 1 & 2. If you wish to enroll in or change optional LTD coverage, complete Sections 1 & 3. Your personnel, payroll, or benefits office will automatically enroll you in Part A (Basic) LTD coverage. Return this form to your personnel, payroll, or benefits office. If you're requesting optional coverage that requires prior approval, you must also complete the LTD Evidence of Insurability Form and send it to Standard Insurance Company. 	<ul style="list-style-type: none"> Review Sections 1 – 3 for completeness and accuracy, and complete Section 4. Do not send the form to Standard Insurance Company or the PEBB Program.

SECTION 1: PERSONAL INFORMATION **Employee completes this section.**

Social Security Number	Employee I.D. Number	Last Name	First Name	Middle Initial
Street Address		Apartment Number	City	State
				ZIP Code + 4
Agency Name	Agency Code	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number – Daytime
				Phone Number – Evening

SECTION 2: BASIC LTD COVERAGE ONLY **Employee completes this section.**

Your employer pays for Plan A (Basic) LTD coverage. Your personnel, payroll, or benefits office will enroll you in this coverage at no cost to you.

If you wish to enroll in Plan A (Basic) LTD coverage only and do not wish to enroll in optional LTD coverage, sign and date below.

I hereby reject my opportunity to enroll in optional long term disability coverage. By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of insurance benefits.

This form replaces all previous forms and submissions I have made for PEBB long term disability coverage.

Employee's signature _____ Date _____

SECTION 3: BASIC AND OPTIONAL LTD COVERAGE **Employee completes this section.**

<p>I wish to:</p> <p><input type="checkbox"/> Enroll in optional LTD coverage; choose a waiting period.</p> <p><input type="checkbox"/> Increase the waiting period for my LTD coverage; choose a waiting period.</p> <p><input type="checkbox"/> Decrease the waiting period for optional LTD coverage; choose a waiting period.</p> <p><input type="checkbox"/> Cancel my optional LTD coverage.</p> <p>If you wish to enroll in optional LTD coverage after 31 days of becoming newly eligible for PEBB coverage, or decrease the waiting period for your optional LTD coverage, you must also complete the LTD Evidence of Insurability Form.</p> <p>By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of insurance benefits.</p> <p>I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by Standard Insurance Company. This form replaces all previous forms and submissions I have made for PEBB long term disability insurance.</p> <p>Employee's signature _____ Date _____</p>	<p>Choose a waiting period:</p> <p><input type="checkbox"/> 30 days</p> <p><input type="checkbox"/> 60 days</p> <p><input type="checkbox"/> 90 days</p> <p><input type="checkbox"/> 120 days</p> <p><input type="checkbox"/> 180 days</p> <p><input type="checkbox"/> 240 days</p> <p><input type="checkbox"/> 300 days</p> <p><input type="checkbox"/> 360 days</p>
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SECTION 4: AGENCY/CARRIER INFORMATION **Personnel, payroll, or benefits office completes this section.**

Current Agency Hire Date	Initial Eligibility Date for PEBB Benefits	Effective Date of Optional Coverage <i>(if no approval required)</i>	Standard Insurance Company has:
Employee's Monthly Earnings	Employee's Current Coverage		<input type="checkbox"/> Approved
\$	<input type="checkbox"/> Basic LTD only		Effective date _____
	<input type="checkbox"/> Optional LTD—waiting period _____ days		<input type="checkbox"/> Declined
			<input type="checkbox"/> Pended—information incomplete

2008 PEBB LONG TERM DISABILITY INSURANCE CONTRACTOR

Standard Insurance Company, Attn: Medical Underwriting Department, 900 SW 5th, Portland, OR 97204-1282
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