

**Enrollment and Change**

**To Be Completed By Human Resources**

Group Number 448518	Division	Billing Category	Date of Employment
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**To Be Completed By Applicant**

- Apply for Coverage     
  Name Change      Former Name \_\_\_\_\_  
 Add Dependent     
  Delete Dependent      Date of Add/Delete \_\_\_\_\_  
 Beneficiary Change **Complete Beneficiary Section**

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name <b>Eye Physicians &amp; Surgeons of WNY PLLC</b>	Hours Worked Per Week		
Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

**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.

<p><b>Life Insurance</b></p> <input type="checkbox"/> Basic Life with AD&D (Employer Paid) <p>You may choose one of the following options:</p> <input type="checkbox"/> Additional Life (Employee Paid) requested amount \$ _____ <input type="checkbox"/> Additional Life with AD&D (Employee Paid) requested amount for Life \$ _____ for AD&D \$ _____
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<p><b>Dependents Life Insurance</b></p> <p>You may choose one of the following options for your Spouse:</p> <input type="checkbox"/> Spouse Life (Employee Paid) requested amount \$ _____ <input type="checkbox"/> Spouse Life with AD&D (Employee paid) requested amount for Life \$ _____ for AD&D \$ _____ <p>You may choose one of the following options for your Child(ren):</p> <input type="checkbox"/> Child(ren) Life (Employee Paid) requested amount \$ _____ <input type="checkbox"/> Child(ren) Life with AD&D (Employee paid) requested amount for Life \$ _____ for AD&D \$ _____
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<p><b>Short Term Disability Insurance</b></p> <input type="checkbox"/> Short Term Disability (Employee Paid)
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Your Full Name

**Beneficiary**

*This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, 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	DOB	Phone No.	SSN if known	Relationship	% of Benefit*
Contingent — Full Name	Address	DOB	Phone No.	SSN if known	Relationship	% of Benefit*

\*Total must equal 100%

**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, and I understand that they form the basis of any coverage under the Group Policy(ies) and Certificate(s). I understand that any misstatements which are material to the issuance of coverage may be used as a basis for contesting the validity of my insurance and/or denial of payment of a claim. I agree to notify The Standard Life Insurance Company of New York (The Standard) of any change in my medical condition while my enrollment application is pending. I acknowledge that I have read the Fraud Notice. 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) and Certificate(s), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies) and Certificate(s).

Signature of Applicant (Member/Employee)

Date

Your Full Name

**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 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.

