

Please refer to your Administration Guide for further instructions on completing this form. New employees and increases in coverage may be subject to eligibility/Evidence Of Insurability/Late Enrollment Penalty requirements. **An enrollment form is required and should be kept on file by you for all contributory and life coverages.**

Group Name			Policy/DIV No.	
Form Prepared by	Phone No.	email		Date Prepared

Employee Additions

1. Social Security Number	Name: Last, First, Middle Initial		Birthday: MM/DD/YYYY		<input type="checkbox"/> Male <input type="checkbox"/> Female
State of Employment	Billing Category	Earnings <input type="checkbox"/> Week amount \$ _____ <input type="checkbox"/> Hour amount \$ _____ <input type="checkbox"/> Month amount \$ _____ <input type="checkbox"/> Year amount \$ _____			
Hours per week if less than 40	Date of Full-time Employment	Job Title/Occupation			
Family Indicator <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee & Children					
Contributory Benefits <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, List:		Note: Some contributory benefits require Evidence Of Insurability or a Late Enrollment Penalty. Please consult your Group Policy or Administration Manual.			

2. Social Security Number	Name: Last, First, Middle Initial		Birthday: MM/DD/YYYY		<input type="checkbox"/> Male <input type="checkbox"/> Female
State of Employment	Billing Category	Earnings <input type="checkbox"/> Week amount \$ _____ <input type="checkbox"/> Hour amount \$ _____ <input type="checkbox"/> Month amount \$ _____ <input type="checkbox"/> Year amount \$ _____			
Hours per week if less than 40	Date of Full-time Employment	Job Title/Occupation			
Family Indicator <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee & Children					
Contributory Benefits <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, List:		Note: Some contributory benefits require Evidence Of Insurability or a Late Enrollment Penalty. Please consult your Group Policy or Administration Manual.			

3. Social Security Number	Name: Last, First, Middle Initial		Birthday: MM/DD/YYYY		<input type="checkbox"/> Male <input type="checkbox"/> Female
State of Employment	Billing Category	Earnings <input type="checkbox"/> Week amount \$ _____ <input type="checkbox"/> Hour amount \$ _____ <input type="checkbox"/> Month amount \$ _____ <input type="checkbox"/> Year amount \$ _____			
Hours per week if less than 40	Date of Full-time Employment	Job Title/Occupation			
Family Indicator <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee & Children					
Contributory Benefits <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, List:		Note: Some contributory benefits require Evidence Of Insurability or a Late Enrollment Penalty. Please consult your Group Policy or Administration Manual.			

4. Social Security Number	Name: Last, First, Middle Initial		Birthday: MM/DD/YYYY		<input type="checkbox"/> Male <input type="checkbox"/> Female
State of Employment	Billing Category	Earnings <input type="checkbox"/> Week amount \$ _____ <input type="checkbox"/> Hour amount \$ _____ <input type="checkbox"/> Month amount \$ _____ <input type="checkbox"/> Year amount \$ _____			
Hours per week if less than 40	Date of Full-time Employment	Job Title/Occupation			
Family Indicator <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Employee & Children					
Contributory Benefits <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, List:		Note: Some contributory benefits require Evidence Of Insurability or a Late Enrollment Penalty. Please consult your Group Policy or Administration Manual.			

FAX OPTION: To ensure **prompt processing** of employee changes, please FAX this form toll free to 1-800-378-2403 or you may mail this form to the address above or sign-up to update your membership data on-line with E-Billing Administration (visit our demonstration site at www.standard.com/ebusiness). Changes shown here will be reflected on a subsequent billing statement.

Please enter changes and terminations on side two.

Please use this portion of the form for employee changes, corrections, or terminations, and dependent changes, corrections, or deletions. New benefits and increases in coverage may be subject to eligibility/Evidence of Insurability/Late Enrollment Penalty requirements.

Group Name			Policy/DIV No.	
Form Prepared by	Phone No.	email		Date Prepared

Employee Changes or Corrections

Social Security No.	Employee Name (Last, First, Middle Initial)	Effective Date of Change	New Billing Category	New Earnings	Coverage Type
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	
				<input type="checkbox"/> WK <input type="checkbox"/> HR <input type="checkbox"/> MO <input type="checkbox"/> YR	

Employee Terminations

Social Security No.	Employee Name (Last, First, Middle Initial)	Date of Termination	Reason for Termination

Comments

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