

# Optional Life Insurance Enrollment Form



Standard Insurance Company

Group Number 753781

844-289-2306  
800 SW Jackson, Ste 1110, Topeka, KS 66612

## Applicant Information

Your Social Security Number	Your Name (First, MI, Last)
Mailing Address	Telephone Number
City, State, Zip	Email Address
Date of Birth	Gender

## Coverage Information

Please refer to your Employee Benefits Guide for Optional Life coverage options available to you and evidence of insurability requirements: [standard.com/eforms/20564\\_753781.pdf](http://standard.com/eforms/20564_753781.pdf)

### Member Life Insurance

In \$5,000 increments up to plan max \$400,000

Current Coverage	+ Coverage Increase	= Total New Coverage Amount
_____	_____	_____

**Note: Member may not be insured as both a member and a dependent.**

### Spouse Life Insurance

In \$5,000 increments up to plan max \$100,000 Spouse Life requested amount \$ \_\_\_\_\_

Spouse Social Security Number \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_

Spouse Name (First, MI, Last) \_\_\_\_\_ Gender \_\_\_\_\_

Spouse Former Name (First, MI, Last) *Complete only if you've had a name change* \_\_\_\_\_

**Note: Spouse does not include a person who is a full-time member of the armed forces of any country.**

### Child Life Insurance

Requested amount (check one)  \$10,000  \$20,000

**Note: Only one member may cover child(ren) if member and spouse work for KPERs.** One premium provides coverage for all eligible children in your family. Children eligible until age 26. No age limit for disabled dependents. **Child does not include a person who is a full-time member of the armed forces of any country.**

## Signature

I wish to make the choices indicated on this form. I authorize deductions from my wages to cover premiums. I understand that my deduction amount will change if my coverage or costs change. I understand that I must be actively at work the day before my coverage effective date in order for my coverage to become effective. Otherwise, my coverage will not become effective until the day after I complete one full day of active work as an active member.

Employee Signature Required \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_

## Employer Information *(to be completed by employer)*

Employer Name \_\_\_\_\_ Date of Hire \_\_\_\_\_ Employer Number \_\_\_\_\_

New Hire  Family Status Change  Increase  Open Enrollment  KBOR  KP&F

Please return completed form to your HR department.