

# Standard Insurance Company

## ADDITIONAL LIFE INSURANCE ENROLLMENT OR CHANGE OF BENEFICIARY

Forward to: MACoHCT Administration PO Box 6668, Helena MT 59604

### REQUIRED EMPLOYEE INFORMATION

Employee's Name (Last, First, Middle)		SS#	Date of Birth	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Employee's Home Address		Home Phone Number	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D / Legally Separated	
Employer's Name	Group No.	Group Policy Number MACoHCT 643418		Occupation / Job Title
Date of Employment	Date Eligible	* Effective Date of Coverage	Hours Worked Per Week	

\*For office use only

### OPTION 1

Complete This Section if Your County Provides EMPLOYER Paid Life & AD&D

Dependent Life  Y  N

**BENEFICIARY** (\*see definitions on back of this form)

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

### OPTION 2

Complete This Section if You Elected EMPLOYEE Paid Life & AD&D

Requested Amount \$ \_\_\_\_\_ Dependent Life  Y  N

\*Medical History Statement required if requesting more than \$50,000 in Option 2 additional life insurance.

**BENEFICIARY** (\*see definitions on back of this form)

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

## OPTION 1 - EMPLOYER Paid Life Insurance Change of Beneficiary

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

## OPTION 2 - EMPLOYEE Paid Life Insurance Change of Beneficiary

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed

**NEW ENROLLMENT:** THIS APPLICATION CANNOT BE PROCESSED UNLESS IT IS COMPLETELY FILLED OUT, SIGNED AND DATED.

**BENEFICIARY CHANGE ONLY:** COMPLETE REQUIRED EMPLOYEE INFORMATION ON *FRONT* OF FORM AND BENEFICIARY INFORMATION ON *BACK* OF FORM. SIGNATURE AND DATE REQUIRED.

### Beneficiary Information

- Your designation revokes all prior designations (but does not change any beneficiary designation you made for Basic Life coverage associated with the MACoHCT medical plan).
- 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 any 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.