Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
164657			

To Be Completed By Applicant ☐ Apply for Coverage ☐ Name Change

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address		City	State / ZIP
Former Name (Last, First, Middle) *Complete only if name change*		Phone Number	
Employer Name **Lee County Board of County Commissioners**		Job Title/Occupation	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Long Term Disability ☒ Employer Paid LTD

Voluntary Short Term Disability ☐ Employee Paid STD

Your age (as of last January)	**Rate** per $10 of STD benefit
<30	$0.702
30-39	$0.358
40-49	$0.388
50-59	$0.494
60-64	$0.702
65+	$1.180

To calculate your monthly payroll deduction, use the formula indicated below:

1. Enter your average weekly earnings, not to exceed $833.00 on Line 1. Line 1: _____
2. Multiply your weekly earnings (Line 1) by $10.00 and enter on Line 2. Line 2: _____
3. Select your rate from the rate table and enter on Line 3. Line 3: _____
4. Multiply Line 2 by the amount entered on Line 3. Line 4: _____
5. Divide the amount entered on Line 4 by 10 and enter on Line 5. Line 5: _____

The amount shown on Line 5 is your estimated monthly payroll deduction.

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.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Human Resources Department.