Reset

Standard Insurance Company
CTA Benefits and Services
PO Box 4744 Portland OR 97208
Tel & TTY 800.522.0406 Fax 888.414.0393

Disability and/or Life Application for Enrollment for CTA-endorsed Plans

For additional information and forms visit CTAMemberBenefits.org/TheStandard

Please be sure to complete all sections to ensure prompt processing of your enrollment. Sign and date the completed form and return it to The Standard at the address above or fax to 888.414.0393.

EMPLOYEE INFORMATION Note: All fields are required.

FIRST NAME	MIDDLE INITIAL	LAST NAME

HOME MAILING ADDRESS	CITY	STATE	ZIP

PRIMARY PHONE	PERSONAL EMAIL ADDRESS

DATE OF BIRTH	GENDER	QUALIFYING FAMILY STATUS CHANGE WITHIN THE LAST 60 DAYS?
	☐ Male ☐ Female	☐ No ☐ Yes Effective Date_____ Type _____

SCHOOL DISTRICT *Please do not abbreviate.*	DATE FIRST EMPLOYED AT CURRENT SCHOOL DISTRICT?

CURRENTLY WORKING?	ANNUAL CONTRACT OR EQUIVALENT WITH YOUR EMPLOYER?
☐ Yes Hours Per Week_____ ☐ No	☐ Yes ☐ No

WHAT IS YOUR JOB TITLE?	FULL TIME MEMBER OF THE ARMED FORCES?
_____	☐ Yes ☐ No

ARE YOU CURRENTLY (OR IN THE PROCESS OF BECOMING) A CTA MEMBER?
☐ Yes ☐ No *You must be an active member to have coverage.*

COVERAGES

Refer to the enrollment materials provided when completing this form. Coverage may be subject to evidence of insurability (satisfactory proof of good health) requirements. If you have questions, please call The Standard's dedicated CTA Customer Service Department at 800.522.0406 or email ctaservice@standard.com.

Disability Insurance

☐ **Disability**

Gross Annual Salary
(Required)
$_____

Life Insurance and Dependents Life Insurance

SELF
- ☐ $25,000
- ☐ $50,000
- ☐ $75,000
- ☐ $100,000
- ☐ $150,000
- ☐ $200,000
- ☐ $250,000
- ☐ $300,000
- ☐ $350,000
- ☐ $400,000

DEPENDENTS (choose one or both)

Spouse/Domestic Partner
- ☐ $12,500
- ☐ $25,000
- ☐ $37,500
- ☐ $50,000
- ☐ $75,000
- ☐ $100,000

Spouse/Domestic Partner and Children
- ☐ $5,000

Dependent Information
- ☐ Spouse/Domestic Partner
- ☐ Child(ren) Number of Child(ren)_____

Please Note: The amount of Dependents Life Insurance **for each dependent** including spouse/domestic partner may not exceed 50% of your Life Insurance amount under the Group Policy.

SIGNATURE REQUIRED

I wish to make the choices indicated on this form. I authorize my employer to deduct premiums from my wages to cover my cost of insurance sponsored by California Teachers Association. I understand that my employer may provide updated payroll information to The Standard either periodically or at The Standard's request to ensure proper premium deductions are being made for my coverage. I understand that a copy of this form will be provided to my employer to facilitate payroll deduction for the coverages that I have elected. I understand that my premium deduction amount will change if my coverage or costs change. This authorization will remain in effect until cancelled by me or by The Standard. I certify that I meet the eligibility requirements of the coverage(s) for which I applied and understand that if I am no longer eligible my coverage(s) will end. I also certify that the information I have provided is accurate.

I understand that Disability Insurance coverage will not pay for benefits for disability due to any diagnosed mental or physical condition for which I have received treatment, care, services or taken prescription medication in the 30 calendar days prior to my insurance effective date unless I have worked 10 consecutive regular days of required attendance after my insurance effective date and prior to becoming disabled.

Electronic Signature ☐ I agree **Date** _____

By clicking the box marked "I agree," I acknowledge that I am signing this document electronically. I understand that this electronic signature shall be enforceable under the applicable state or federal law and is equivalent to a manual signature.

Remember to print a copy for your records before using the "Submit" button.

Print Submit