

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 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	QUALIFYING FAMILY STATUS CHANGE WITHIN THE LAST 60 DAYS? <input type="checkbox"/> No <input type="checkbox"/> Yes Effective Date _____ Type _____		
SCHOOL DISTRICT <i>Please do not abbreviate.</i>		DATE FIRST EMPLOYED AT CURRENT SCHOOL DISTRICT?		
CURRENTLY WORKING? <input type="checkbox"/> Yes Hours Per Week _____ <input type="checkbox"/> No		ANNUAL CONTRACT OR EQUIVALENT WITH YOUR EMPLOYER? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WHAT IS YOUR JOB TITLE? _____		FULL TIME MEMBER OF THE ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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	Life Insurance and Dependents Life Insurance	
<input type="checkbox"/> Disability Gross Annual Salary (Required) \$ _____	<u>SELF</u> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$400,000	<u>DEPENDENTS (choose one or both)</u> Spouse/Domestic Partner <input type="checkbox"/> \$12,500 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$37,500 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 Spouse/Domestic Partner and Children <input type="checkbox"/> \$5,000 Dependent Information <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren) Number of Child(ren) _____ Please Note: The amount of Dependents Life Insurance for each dependent 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.