Standard Insurance Company

Reset

Enrollment and Change

To Be Completed By Human Resources

Group Name	Group Number	Division	Billing Category	Date of Employment
Washington Counties Insurance Fund (WCIF)	**645273**	**00**	**0001**	

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			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 Insurance

☒ Base LTD (Employer Paid)

To request Buy-up LTD insurance please check the box below

☐ Buy-up LTD

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) _____

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