Reset

WA Health Care Authority
School Employees Benefits Board (SEBB) Program
Long Term Disability (LTD) Insurance
Enrollment and Change Form

Standard Insurance Company

To Be Completed By Employee

☐ Apply for Coverage ☐ Name Change ☐ Making a Benefit Change

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	Employee I.D. Number	
Your Address		City	State	Zip Code
Former Name (Last, First, Middle) *Complete only if you are reporting a name change*		Phone Number	☐ Male ☐ Female	
Job Title/Occupation				
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Long Term Disability (LTD) Insurance Coverage

I wish to:

☒ Enroll in basic LTD (Employer Paid)

☐ Enroll in supplemental LTD (Employee Paid) (90 day waiting period before coverage begins)

☐ Cancel my supplemental LTD coverage

During the 2020 plan year, Evidence of Insurability is not required for new enrollees. However, if you previously enrolled in SEBB supplemental LTD coverage and disenrolled, Evidence of Insurability will be required as a condition of reenrollment into the plan.

Beginning January 1, 2021, if you request supplemental LTD coverage after 31 days of becoming newly eligible for SEBB coverage, you must also complete the LTD Evidence of Insurability form and send it to Standard Insurance Company (The Standard) at 900 SW 5th, Portland, OR 97204-1282 or call 1-833-229-4177. **Note:** Enrollment and Change Forms are maintained by the SEBB Organization and should not be sent to The Standard.

To Be Completed By Employee's Payroll or Benefits Office Staff

Employer Name **WA Heath Care Authority** **School Employees Benefits Board (SEBB) Program**		Group Number **756494**	Effective Date of Coverage *(if no approval required)*
Agency Name		Agency Code	
Current Agency Hire Date	Initial Eligibility Date for SEBB Benefits	Employee's Current Coverage ☐ basic LTD ☐ supplemental LTD – waiting period 90 days	

Signature I wish to make the choices selected 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.

If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.

This form replaces all previous forms and submissions I have made for the SEBB Program's long term disability coverage.

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

Print

Return completed form to your payroll or benefits office.