

Group Insurance Enrollment Form

**Standard Insurance Co.
Portland, Oregon**

Please Print

Group Number 988698	Suffix	Group Name San Diego Fireman's Relief Association	Social Security Number	
Member Name (<i>Last, First, M.I.</i>)			Male <input type="checkbox"/>	Birthdate Month/Day/Year
			Female <input type="checkbox"/>	
Date Employed Month/Day/Year N/A	Workplace Location (<i>State</i>) California	Coverage(s) applying for: <input checked="" type="checkbox"/> Life <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Voluntary/Additional Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Voluntary AD&D <input type="checkbox"/> STD <input checked="" type="checkbox"/> LTD <input type="checkbox"/> Other _____		Eff. Date of Insurance Month/Day/Year 8/1/08
Occupation Firefighter	Hours Worked Each Week For This Employer (Not incl. overtime) N/A	Base Earnings From This Employer \$ N/A	Hr. <input type="checkbox"/> Wk. <input type="checkbox"/>	Mo. <input type="checkbox"/> Yr. <input type="checkbox"/>

Complete beneficiary designation for Life and Life/AD&D coverages. Unless specified otherwise on a separate sheet of paper, this designation will also apply to any Voluntary AD&D coverage. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary information.

Primary – Full Name	Address	S.S. No.	Relationship	% of Benefit

Contingent – Full Name	Address	S.S. No.	Relationship	% of Benefit

I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. 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.

X _____ Date _____

Note: Beneficiary designation is not valid unless this form is signed and dated.

Group Administrator Use Only: Use this area to record initial amounts as well as future changes.

Effective Date	Class	Life/AD&D Amount	Dependents Life Amount	Voluntary AD&D Amount	Vol./Additional Life Amount	STD Benefit Volume	LTD Insured Earnings

Group Administrator: Do not send this form to The Standard unless asked to do so. Keep this form in your file.