

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name Montana University System		Group Number(s) 643129			
	Your Address		City		State	ZIP		
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation			
LIFE	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Basic Life with AD&D Insurance <input type="checkbox"/> Option 1: \$15,000 Life with AD&D Employer Paid <input type="checkbox"/> Option 2: \$30,000 Life with AD&D Employer Paid <input type="checkbox"/> Option 3: \$48,000 Life with AD&D Employer Paid Additional/Optional Life Insurance <input type="checkbox"/> Additional/Optional Life Your requested amount \$ _____ <input type="checkbox"/> Decline Additional/Optional Life Dependents Life Insurance <input type="checkbox"/> Spouse Life Requested amount \$ _____ <input type="checkbox"/> Decline Spouse Life Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Child Life Requested amount \$ _____ <input type="checkbox"/> Decline Child Life Child Name _____ Date of Birth _____ Voluntary AD&D Insurance <input type="checkbox"/> Voluntary AD&D Your requested amount \$ _____ <input type="checkbox"/> Decline Voluntary AD&D							
	DISABILITY	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Long Term Disability <input type="checkbox"/> Plan 1: Employer Paid LTD only <input type="checkbox"/> Plan 2: Buy-up LTD to 66 2/3 Plan with 180-day Benefit Waiting Period <input type="checkbox"/> Plan 3: Buy-up LTD to 66 2/3 Plan with 120-day Benefit Waiting Period <input type="checkbox"/> Decline LTD Options						
		BENEFICIARY	<i>This designation applies to Basic Life with AD&D, Additional Life and Voluntary AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>					
			Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
Contingent - Full Name			Address		Soc. Sec. No.	Relationship % of Benefit		
CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____							
	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. 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 above.						
Member/Employee Signature Required				Date (Mo/Day/Yr)				
Human Resources Department - Complete this section. Retain form for your records.								
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr			

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.