Reset

**WA Health Care Authority**
**Public Employees Benefits Board (PEBB) Program**
**Long Term Disability (LTD) Insurance**
**Enrollment and Change Form**

Standard Insurance Company

## To Be Completed By Employee ☐ Applying for Coverage ☐ Making a Change

***Return completed form to your payroll or benefits office.***

| 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 | | | | |

**Long Term Disability (LTD) Insurance Coverage**

I wish to:

☒ Enroll in Employer-Paid LTD

☐ Enroll in the 60% income replacement Employee-Paid LTD

☐ Enroll in the 50% income replacement Employee-Paid LTD

☐ Decline/cancel Employee-Paid LTD

If you wish to enroll or increase your Employee-Paid LTD coverage more than 31-days after becoming eligible for PEBB Program benefits, you must also complete the LTD Evidence of Insurability form available at **hca.wa.gov/pebb** under *Forms and publications.* You may request a paper form from your employer**. Note:** Send the Evidence of Insurability form to Standard Insurance Company (The Standard) at 900 SW 5th, Portland, OR 97204-1282 or call The Standard at 1-800-368-2860. The Enrollment and Change Forms are maintained by the PEBB employer and should not be sent to The Standard.

**Signature** I wish to make the changes selected on this form. If electing coverage, I authorize deductions from my wages to cover the cost of 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 or canceling Employee-Paid LTD 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/canceled above.

This form replaces all previous forms and submissions I have made for the PEBB Program's Long Term Disability coverage.

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

***Return completed form to your payroll or benefits office.***

## To Be Completed By Payroll or Benefits Office Staff

| Employer Name<br>**WA Health Care Authority**<br>**Public Employees Benefits Board (PEBB) Program** | Group Number<br>**377661** | Effective Date of Coverage *(if no approval required)* |
|---|---|---|
| Agency Name | Agency Code | |
| Current Agency Hire Date | Initial Eligibility Date for PEBB Benefits | |
| Hours Worked Per Week | Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year | |

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