Standard Insurance Company

Enrollment and Change

To Be Completed By Human Resources

Group Number	Classification	Date of Employment	Effective Date of Eligibility
648725	Active Employees		

To Be Completed By Applicant

☐ Initial Enrollment ☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.*
☐ Coverage Change Date of change _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Mailing Address	City	State / Territory	ZIP

Employer Name	Phone Number
Government of Guam	

Do you work 20 hours or more? ☐ Yes ☐ No	Job Title/Occupation	Agency/Department Number

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

Basic Life Insurance ☒ Basic Life with AD&D $10,000 (Employer Paid)

Additional Life Insurance

You may choose one of the following options for yourself:

☐ Additional/Optional Life with AD&D (Employee Paid) (See Coverage Highlights for bi-weekly age-banded premium rates)

☐ $30,000 ☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000 ☐ $55,000 ☐ $60,000 ☐ $65,000 ☐ $70,000 ☐ $75,000
☐ $80,000 ☐ $85,000 ☐ $90,000 ☐ $95,000 ☐ $100,000 ☐ $105,000 ☐ $110,000 ☐ $115,000 ☐ $120,000

☐ Decline Additional/Optional Life with AD&D

Dependents Life Insurance ☐ Decline Spouse Life / Child(ren) Life

☐ Spouse Life $10,000 / Child(ren) Life $8,000 (Employee Paid) (See Coverage Highlights for bi-weekly premiums)

Beneficiary ***This designation applies to Basic Life with AD&D or Additional Life Insurance available through your Employer, if any. Separate beneficiaries may be selected for each coverage. Check the appropriate box below for each beneficiary. If a minor (a person not of legal age) is a beneficiary, please include the name, address and phone number of the minor's guardian, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Life Plan	Primary - Full Name	Mailing Address	Phone Number	Soc. Sec. No./DOB	Relationship	% of Benefit
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						

Life Plan	Contingent - Full Name	Mailing Address	Phone Number	Soc. Sec. No./DOB	Relationship	% of Benefit
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						
☐ Basic ☐ Add'l						

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 as declined above.

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

EMPLOYER USE ONLY		AUDIT PURPOSE ONLY		
Validated GovGuam/The Standard Agent	Date	Audit Date	Pay Period	Amount Deducted

Premium Rate ☐ Composite Rate ☐ Age-Banded Rate

Distribution: White – The Standard Canary – Personnel Pink – Payroll Golden – Employee