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

PLEASE CHOOSE FROM ONE OF THE OPTIONS ON THE LEFT. IF NO CHOICE IS MADE, YOU WILL BE DEFAULTED INTO THE EMPLOYEE-PAID 60% COVERAGE.

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