Reset

WA Health Care Authority
School Employees Benefits Board (SEBB) 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 SEBB Program benefits, you must also complete the LTD Evidence of Insurability form available at **hca.wa.gov/sebb** 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 SEBB 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 SEBB 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 **WA Health Care Authority** **School Employees Benefits Board (SEBB) Program**	Group Number **756494**	Effective Date of Coverage *(if no approval required)*
Agency Name	Agency Code	
Current Agency Hire Date	Initial Eligibility Date for SEBB Benefits	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year	

Print