Reset

Standard Insurance Company

Public Employees Benefits Board (PEBB)
Long Term Disability (LTD)
Enrollment/Change Form

To Be Completed By Applicant ☐ Apply for Coverage ☐ Name Change

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	
Agency Name	Agency Code	Job Title/Occupation		
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year			

Long Term Disability (LTD) Insurance Coverage

I wish to:

☒ Enroll in basic LTD (Employer Paid)

☐ Enroll in optional LTD (Employee Paid); choose a waiting period.

☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Increase the waiting period for my optional LTD coverage; choose a waiting period.

☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Decrease the waiting period for my optional LTD coverage; choose a waiting period.

☐ 90 days ☐ 120 days ☐ 180 days ☐ 240 days ☐ 300 days ☐ 360 days

☐ Cancel my optional LTD coverage.

If you request optional LTD coverage after 31 days of becoming newly eligible for PEBB coverage, or decrease the waiting period for your optional LTD coverage, you must also complete the LTD Evidence of Insurability form and send it to Standard Insurance Company (The Standard) at 900 SW 5th, Portland, OR 97204-1282 or call 1-800-368-2860.

To Be Completed By Personnel, Payroll, or Benefits Office Staff

Employer Name		Group Number	Effective Date of Coverage *(if no approval required)*
Public Employees Benefits Board (PEBB)		**377661**	
Current Agency Hire Date	Initial Eligibility Date for PEBB Benefits	Employee's Current Coverage ☐ basic LTD ☐ optional LTD – waiting period _____days	

Signature I wish to make the choices selected 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.

This form replaces all previous forms and submissions I have made for PEBB Long term disability coverage.

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

Print

Return completed form to your personnel, payroll or benefits office.