Reset

The Standard Life Insurance Company of New York **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
761932			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change ***Complete Beneficiary Section below.*** ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete_____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address		City	State / ZIP
Former Name (Last, First, Middle) *Complete only if name change*		Phone Number	
Employer Name **New York State Teamsters Council Health and Hospital Fund**		Job Title/Occupation	
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***
(Guarantee Issue Amount for Employee is $50,000, Spouse $10,000, Child $4,000)

Life Insurance

☐ Additional Life (Employee Paid) requested amount $_____

☐ Voluntary AD&D requested amount $_____

Dependents Life Insurance (Employee Paid)

☐ Spouse Life requested amount $_____ Spouse Name_____

☐ Child(ren) Life $4,000

Voluntary Accidental Death and Dismemberment (AD&D) (Employee Paid)

☐ Employee Voluntary AD&D requested amount $_____

☐ Your Spouse Voluntary AD&D requested amount $_____

☐ Your Child(ren) Voluntary AD&D requested amount $_____

Beneficiary ***This designation applies to your Life and Accidental Death and Dismemberment Insurance if any, available through your Employer. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Return the completed form to your Human Resources Department.

SNY **10789**

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(1/23)

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Total must equal 100%

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. I acknowledge I have read the fraud notice below.

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

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian, or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____ ."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Fraud Notice

Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Return the completed form to your Human Resources Department.

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