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

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department (HR Dept.).

APPLICANT

Your Name (Last, First, Middle)		Group Name **Hofstra University**	Group Number(s) **430503**	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	☐ Male ☐ Female	Job Title/Occupation	

DISABILITY

For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept.

Long Term Disability

You must check one from the following options.

☐ Voluntary LTD ☐ Decline Voluntary LTD

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Name Change Former name _____ ☐ Other _____

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.

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 of 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.

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

HR Dept. - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $_____ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr