Standard Insurance Company
PO Box 4744 Portland OR 97208
Tel 800.522.0406 Fax 886.414.0393

Enrollment for School District
Group Disability Insurance

Sign and date the completed form and return it to your Employer. If you have questions about completing this form please contact your Employer.

FIRST NAME			MIDDLE INITIAL	SIC USE ONLY GROUP NO.
LAST NAME				
HOME MAILING ADDRESS				
CITY			STATE	ZIP
HOME PHONE	DATE OF BIRTH	GENDER ☐ Male ☐ Female	CONTRACT SALARY $ _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annually	
SCHOOL DISTRICT				

STATUS ☐ Certificated ☐ Classified	HRS WORKED PER WEEK	PAYROLL MODE ☐ 12thly ☐ 10thly ☐ Other _____ ☐ Unknown

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries