

To Be Completed By Human Resources

Group Number 161585	Division	Billing Category	Date of Employment
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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	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP

Former Name (Last, First, Middle) <i>Complete only if name change</i>	Phone Number
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Employer Name South Shore School District	Job Title/Occupation
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Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
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Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*
Long Term Disability Employer Paid LTD

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