

To Be Completed By Human Resources

Group Number 166942	Division	Billing Category	Date of Employment
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To Be Completed By Applicant

- Apply for Coverage Name Change Former Name _____
 Add Dependent Delete Dependent Date of Add/Delete _____

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name Juneau County	Hours Worked Per Week		
Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements. If you choose not to elect any coverage below, in future enrollments, you may be required to provide Evidence of Insurability or be subject to a Late Enrollment penalty.

Long Term Disability Insurance

You must choose one of the following options:

- Long Term Disability (Employee Paid) Decline Long Term Disability (Employee Paid)

Your Full Name

Dental Insurance
 Dental (Employee paid)
Are you or your dependents covered for dental insurance under another plan? Yes No

List dependents to enroll or drop for Dental, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Dental (Employee paid)		Gender		Date of Birth
	Add	Drop	M	F	
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Child 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Dental Insurance Waiver: Contributory Dental Insurance
The insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Entrant Penalty.

I decline Dental insurance for myself.

I decline Dental insurance for one or more dependents.

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 represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee)	Date
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