

**To Be Completed By Risk Management & Insurance**

Group Number <b>755556</b>	Date of Employment
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**To Be Completed By Applicant**  Apply for Coverage 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	
Employer Name <b>The School Board of Pinellas County, Florida</b>		Job Title/Occupation	
Hours Worked Per Week			

**Coverage** Check with Risk Management & Insurance about coverage options available to you and Evidence Of Insurability requirements.**Life Insurance** Additional Life requested amount \$ \_\_\_\_\_**Dependents Life Insurance** Spouse Life requested amount \$ \_\_\_\_\_

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**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) \_\_\_\_\_

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Reviewer Signature \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_

As a New Hire, you may elect up to the Guaranteed Issue amount of \$100,000 of **employee coverage** **without** having to submit a Medical History Statement.

If you are electing **more** than \$100,000 for **yourself or electing coverage for your spouse**.

Please go to the following website to complete the medical history statement for yourself and /or your spouse,

**[https://www.standard.com/eforms/7533d\\_755556.pdf](https://www.standard.com/eforms/7533d_755556.pdf)**

Return completed form to Risk Management and Insurance.  
Please keep a copy for your records.